

# COVID-19 NOVEL CORONAVIRUS

Please complete the following questions before beginning your work today.

Name: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

## Do you have any of the following:

Yes

No



**Fever**

Yes

No



**Cough**

Yes

No



**Shortness of breath**

Yes

No



**Sore throat**

Yes

No



**Runny nose**

Yes

No



**Feeling unwell**

Yes

No

Have you been in close contact with someone who is sick or has confirmed COVID-19 in the past 14 days?

Yes

No

Have you returned from travel outside Canada in the past 14 days?

**If you answered YES to any of these questions, go home & self-isolate right away. Call Telehealth or your health care provider.**