



# COVID-19 SCREENING

Please complete before entering.

## Symptoms of COVID-19:

- Fever
- Cough
- Headache
- Muscle or joint aches and pains
- Sore Throat
- Chills
- Runny nose
- Pink eye
- Dizziness
- Fatigue
- Nausea or vomiting
- Diarrhea
- Loss of appetite
- Altered sense of taste or smell
- Shortness of breath
- Difficulty breathing

1. In the last 48 hours, have you experienced any new or worsening of the above symptoms?

YES  NO

2. Have you or individuals in your home tested positive for COVID-19, and NOT received clearance from public health?

YES  NO

3. Within the last 14 days, have you been in close contact with a person who has COVID-19 and have been told to self-isolate?

YES  NO

4. Within the last 14 days, have you returned from travelling outside of Canada?

YES  NO



If you answered "YES" to any of the questions above, please do not enter. Return home and you call your Community Health Nurse (or 811) for advice.

