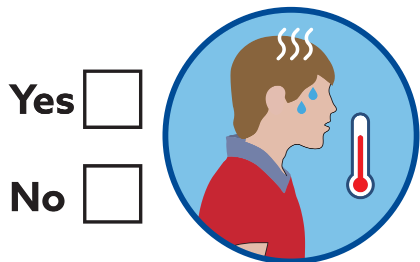
COVID-19

Please complete before entering the school.

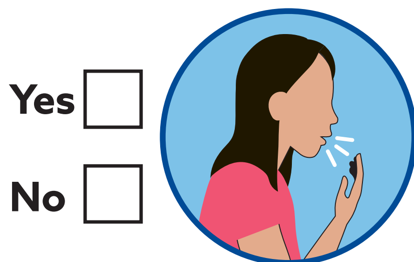
Name: ______________________________

Date: ____________________ Time: ____________________

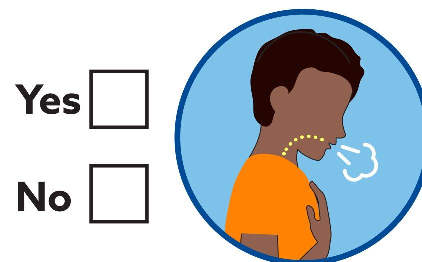
Do you have any of the following (new or worsening):



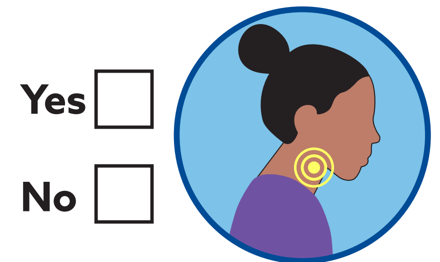
Fever



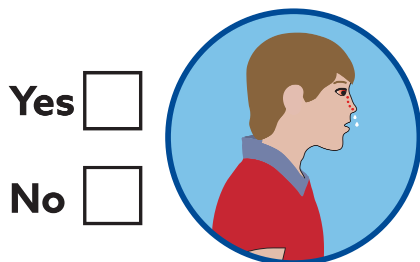
Cough



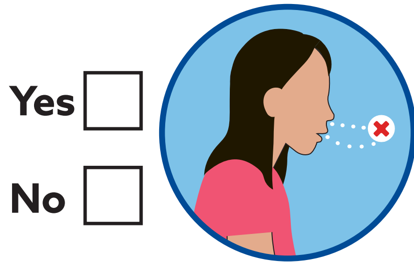
Difficulty breathing



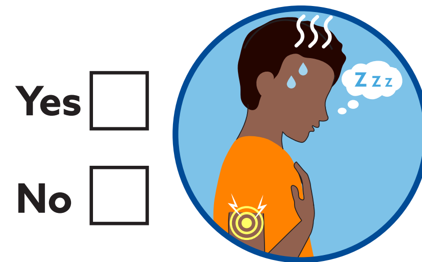
Sore throat, trouble swallowing



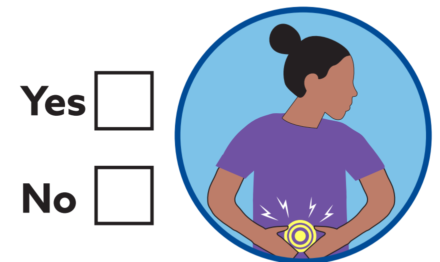
Runny nose or red eyes



Loss of taste or smell



Not feeling well, tired or sore muscles



Nausea, vomiting, diarrhea

Yes ☐ No ☐ Have you been in close contact with someone who has confirmed COVID-19 in the past 14 days without wearing appropriate PPE?

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, to find out if you need a test.