**COVID-19 SCREENING**

**If a visitor answers YES to any of the questions, the individual SHOULD NOT be allowed on the business premises.**

1. **DO YOU HAVE ANY OF THE BELOW SYMPTOMS:**

|  |  |  |
| --- | --- | --- |
| FEVER (> THAN 38.0 C) | YES | NO |
| COUGH / SORE THROAT / PAINFUL SWALLOWING | YES | NO |
| RUNNY NOSE / CONGESTION / TROUBLE BREATHING | YES | NO |
| CHILLS / UNWELL / FATIGUED | YES | NO |
| LOSS OF APPETITE / NAUSEA / DIARRHEA / VOMITTING | YES | NO |
| SENSES: LOSS OF TASTE / SMELL / CONJUCTIVITIS | YES | NO |
| MUSCLE AND NOINT ACHES / HEADACHES | YES | NO |

1. **HAVE YOU, OR ANYONE IN YOUR HOUSEHOLD TRAVELLED OUTSIDE OF CANADA IN THE LAST 14 DAYS?**

YES NO

1. **HAVE YOU, OR ANYONE IN YOUR HOUSEHOLD BEEN IN CONTACT IN THE LAST 14 DAYS WITH SOMEONE WHO IS BEING INVESTIGATED OR CONFIRMED TO BE A CASE OF COVID-19, OR WITH A COUGH OR FEVER?**

YES NO

1. **ARE YOU CURRENTLY BEING INVESTIGATED FOR A CASE OF COVID-19?**

YES NO

1. **HAVE YOU TESTED POSITIVE FOR COVID-19 WITHIN THE PAST 10 DAYS?**

YES NO

COVID-19 may pose a higher risk to certain demographics and those with certain health conditions. Are you over the age of 65? Do you have any of the following health conditions: cardiovascular disease, diabetes, acute or chronic respiratory disease, hypertension, cancer, or immunodeficiency? If so; please know that you may be at higher risk even though we will take every precaution possible to keep you safe.

 **Name: Date:**

