NSNS COVID Assessment Form

Date of assessment:

Program Particpant Information

Full name

Department

Email

Phone #

Symptoms

Have you travelled internationally within the last 14 days?

☐ Yes ☐ No

Have you had contact with anyone with confirmed COVID-19 in the last 14 days?

☐ Yes ☐ No ☐ Unsure

Please check the box of each symptom you are currently experiencing or have had in the last 14 days:

	Yes	No	Additional details
Fever, chills, sweating	☐	☐	
Difficulty breathing	☐	☐	
New or worsening cough	☐	☐	
Sore throat	☐	☐	
Body aches	☐	☐	
Vomiting or diarrhea	☐	☐	
None of the above	☐		

Please select all conditions that apply to you:

	Yes	No	Additional details
Asthma or lung disease	☐	☐	
Pregnant	☐	☐	
Weakened immune system	☐	☐	
Cirrhosis of the liver	☐	☐	
Kidney failure	☐	☐	
Congestive heart failure	☐	☐	
Obesity	☐	☐	
Diabetes	☐	☐	
None of the above	☐	☐	

Employee signature

Date