



COVID-19

Please complete the following questions before beginning your work today.

Name: _____ Phone: _____

Date: _____ Time: _____

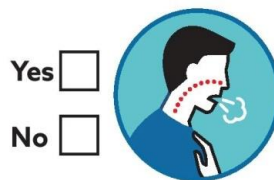
Do you have any of the following:



Fever



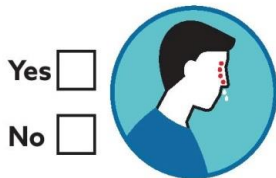
Cough



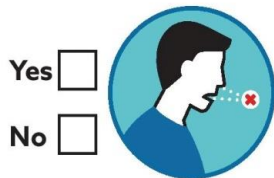
Difficulty breathing



Sore throat,
trouble swallowing



Runny nose



Loss of taste or
smell



Not feeling well



Nausea, vomiting,
diarrhea

Yes Have you been in close contact with someone who is
No sick or has confirmed COVID-19 in the past 14 days?

Yes Have you returned from travel outside Canada in the
No 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.**