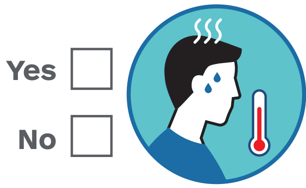
COVID-19

Name: ______________________________

Date: ____________________ Time: ____________________

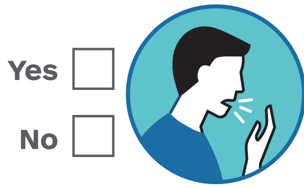
Do you have any of the following:

Yes ☐ No ☐



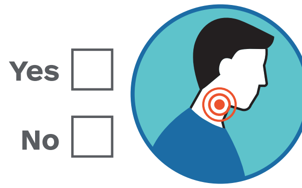
Fever

Yes ☐ No ☐



Cough

Yes ☐ No ☐



Sore throat, trouble swallowing

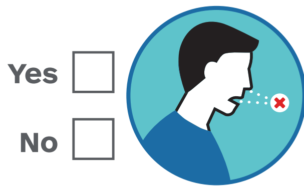
Yes ☐ No ☐

Difficulty breathing

Yes ☐ No ☐

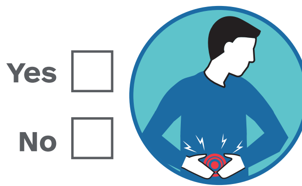
Runny nose

Yes ☐ No ☐



Loss of taste or smell

Yes ☐ No ☐



Nausea, vomiting, diarrhea

Yes ☐ No ☐

Not feeling well

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

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 and self-isolate right away. Call Telehealth or your health care provider, to find out if you need a test.

Adapted with permission from Toronto Public Health

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