

# COVID SCREENING

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Time: \_\_\_\_\_

Phone #: \_\_\_\_\_

Please fill out for all family members travelling with you today

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

In the last 14 days have you

\_\_\_\_ yes \_\_\_\_ no Been Diagnosed with Covid 19

\_\_\_\_ yes \_\_\_\_ no Experienced Fever Shortness of breath, sore throat, cough

\_\_\_\_ yes \_\_\_\_ no Returned to Canada from outside the country

\_\_\_\_ yes \_\_\_\_ no Been in contact with someone that has tested positive for Covid 19

\_\_\_\_ yes \_\_\_\_ no Been in contact with anyone that has been out of the country