COVID-19

Please complete the following questions before beginning your work today.

Name: ____________________________ Date: ____________ Time: ____________

Do you have any of the following new or worsening symptoms?

- Fever/Chills  
  - Yes [ ]  
  - No [ ]

- Cough  
  - Yes [ ]  
  - No [ ]

- Difficulty breathing/Shortness of breath  
  - Yes [ ]  
  - No [ ]

- Sore throat/Difficulty swallowing  
  - Yes [ ]  
  - No [ ]

- Runny nose (unrelated to seasonal allergies)  
  - Yes [ ]  
  - No [ ]

- Loss of taste or smell  
  - Yes [ ]  
  - No [ ]

- Not feeling well, headache, unexplained tiredness and muscle aches  
  - Yes [ ]  
  - No [ ]

- Nausea, vomiting, diarrhea, abdominal pain  
  - Yes [ ]  
  - No [ ]

In the last 14 days, have you had close physical contact with a person who:

- was sick with a respiratory illness (had a new or worsening cough, fever or difficulty breathing)?  
  - Yes [ ]  
  - No [ ]

- has returned from travel outside of Canada in the last 14 days?  
  - Yes [ ]  
  - No [ ]

- was a confirmed or probable case of COVID-19?  
  - Yes [ ]  
  - No [ ]

- In the last 14 days, have you travelled outside of Canada?  
  - Yes [ ]  
  - No [ ]


If you are feeling unwell, contact your health care provider or call Telehealth Ontario at 1-866-797-0000 to speak to a registered nurse.

Adapted with permission from Toronto Public Health

03/08/2020