



# 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?



Yes

No

**Fever/Chills**



Yes

No

**Cough**



Yes

No

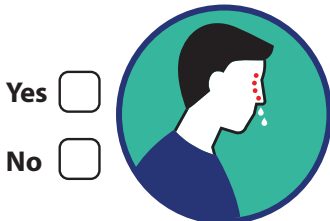
**Difficulty breathing/  
Shortness of breath**



Yes

No

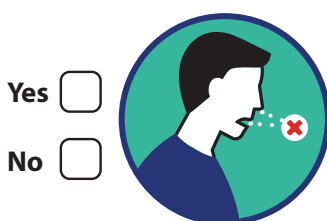
**Sore throat/  
Difficulty swallowing**



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)?
- has returned from travel outside of Canada in the last 14 days?
- was a confirmed or probable case of COVID-19?



Yes

No

**In the last 14 days**, have you travelled outside of Canada?



If you answered **YES** to any of these questions, **please return home and self-isolate**. Visit [OttawaPublicHealth.ca/COVIDCentre](https://OttawaPublicHealth.ca/COVIDCentre) for more information about getting tested.

**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

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