

COVID-19 Symptom Screening Form

1. Are you experiencing any of these symptoms?

- Fever
- **New** or worsening cough
- Difficulty breathing/shortness of breath

 Yes No

2. Are you experiencing any of these **unexplained** symptoms?

- Fatigue/malaise
- Chills
- Sore throat
- Runny nose
- Nasal congestion
- Digestive symptoms (including nausea/vomiting/diarrhea)
- Loss of taste/smell
- Sore muscles
- Conjunctivitis (pink eye)
- Headache

 Yes No

3. Have you been in close contact at home, at work**, or in the community, with someone who is symptomatic and/or is being tested/awaiting test results of COVID-19?

 Yes No

4. Have you been in close contact at home, at work**, or in the community, with someone who has been confirmed to have COVID-19 in the last 14 days?

 Yes No

5. Have you travelled internationally within the last 14 days?

 Yes No

**** Not including those who work with COVID patients in healthcare settings in full personal protective equipment which includes surgical mask/N95 mask/respirator, with eye protection, at all times.**