COVID-19 Symptom Screening Form

1. Are you experiencing any of these symptoms? No

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

2. Are you experiencing any of these **unexplained** symptoms? No

    - 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

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? 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? No

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

I attest that the above is true.

Name

Signature

Date