COVID-19

Please complete the following questions before beginning your work today.

Name: ______________________________

Date: ______________________ Time: ______________________

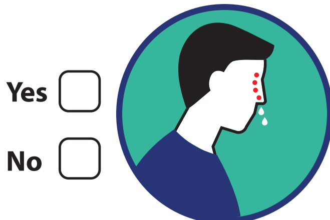
Do you have any of the following new or worsening symptoms?

Fever/Chills

Cough

Difficulty breathing/ Shortness of breath

Sore throat/ Difficulty swallowing



Runny nose (unrelated to seasonal allergies)

Loss of taste or smell

Not feeling well, headache, unexplained tiredness and muscle aches

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** 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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