# STOP COVID-19

Please complete the following questions.

Name: _____

Date: _____ Time: _____

## Do you have any of the following:

Yes ☐ No ☐

Fever

Yes ☐ No ☐

Cough

Yes ☐ No ☐

Difficulty breathing

Yes ☐ No ☐

Sore throat, trouble swallowing

Yes ☐ No ☐

Runny nose

Yes ☐ No ☐

Loss of taste or smell

Yes ☐ No ☐


Not feeling well

Yes ☐ No ☐

Nausea, vomiting, diarrhea

Yes ☐ No ☐ In the past 14 days, have you been in close contact with someone who is sick or has confirmed COVID-19, without wearing appropriate PPE?

Yes ☐ No ☐ Have you returned from travel outside Canada in the past 14 days?

**If you answered YES to any of these questions, please go home & self-isolate right away. Call your health care provider or go to an assessment centre to find out if you need a COVID-19 test.**

Adapted with permission from Toronto Public Health