

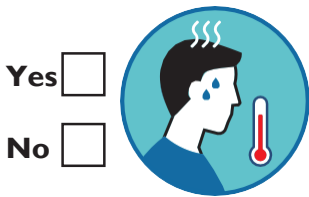
STOP COVID-19

Please complete the following questions.

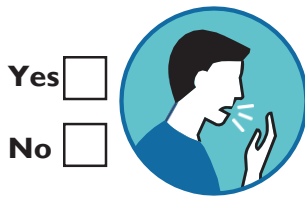
Name: _____

Date: _____ Time: _____

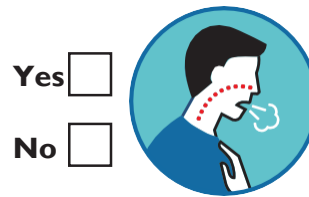
Do you have any of the following:



Fever



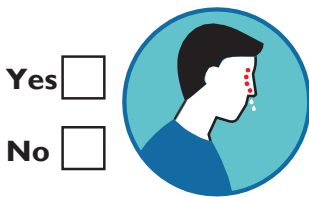
Cough



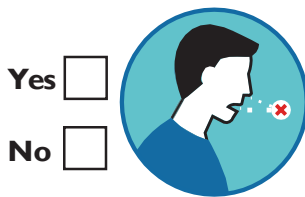
Difficulty breathing



Sore throat,
trouble swallowing



Runny nose



Loss of taste or
smell



Not feeling well



Nausea, vomiting,
diarrhea

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

Yes Have you returned from travel outside Canada in the
No 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