**COVID-19 – Health Screening Form**

1. Have you experienced any of the following signs or symptoms of COVID-19 in the last 14 days? {Check all the apply}

[ ]  Fever

[ ]  Cough

[ ]  Difficulty breathing

[ ]  Muscle aches

[ ]  Fatigue

[ ]  Headache

[ ]  Sore throat

[ ]  Runny nose

1. If you have any of the above symptoms please state how long you have had them (when they started) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Have you traveled outside of Canada in the last 14 days?

 YES NO

1. Have you been in contact with someone who has tested positive for COVID-19?

YES NO

I hereby agree that the information provided on this form is accurate.

Employee Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_