STOP
THE SPREAD OF COVID-19

PLEASE COMPLETE THE FOLLOWING QUESTIONS BEFORE BEGINNING YOUR DAY.

NAME _____ DATE D / M / Y TIME _____

DO YOU HAVE ANY OF THE FOLLOWING NEW OR WORSENING SYMPTOMS?

FEVER / CHILLS YES NO	COUGH YES NO	DIFFICULTY BREATHING / SHORTNESS OF BREATH YES NO	SORE THROAT / DIFFICULTY SWALLOWING YES NO
RUNNY NOSE (UNRELATED TO SEASONAL ALLERGIES) YES NO	LOSS OF TASTE OR SMELL YES NO	FEELING UNWELL, HEADACHE, MUSCLE ACHES, UNEXPLAINED TIREDNESS YES NO	NAUSEA, ABDOMINAL PAIN, VOMITING, DIARRHEA YES NO

IN THE LAST 14 DAYS, HAVE YOU HAD CLOSE PHYSICAL CONTACT WITH A PERSON WHO:

- WAS SICK WITH A RESPIRATORY ILLNESS?
- RETURNED FROM TRAVEL OUTSIDE OF CANADA IN THE LAST 14 DAYS?
- WAS A CONFIMRED OR PROBABLE CASE OF COVID-19?

YES NO

IN THE LAST 14 DAYS, HAVE YOU TRAVELED OUTSIDE OF CANADA? YES NO

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.