Name of Customer: _____ Date: _____

1. Have you travelled outside of Canada in the last 14 days (please check mark box)?

YES□ or NO□

2. Has someone you are in close contact with tested positive for COVID-19 in the last 14 days?

YES□ or NO□

3. Are you in close contact with a person who is sick with new respiratory symptoms or who recently traveled outside of Canada?

YES □ or NO □

4. Do you have a fever? (temperature ≥ 37.8 °C)

YES□ or NO□

5. Do you have any of these symptoms* YES or NO :

□ Chills

□ New or worsening cough (dry or productive)

□ Barking cough (croup)

□ Shortness of breath/difficulty breathing

□ Sore throat

□ Difficulty swallowing

□ Loss of taste or smell

□ Pink eye (conjunctivitis)

□ Headache that is unusual or long-lasting

□ Runny or stuffy nose (not related to seasonal allergies or other known causes or conditions)

□ Nausea/vomiting/diarrhea/abdominal pain

□ Muscle aches

□ Unexplained fatigue/malaise

□ Falling more than usual □
Other_____

6. Are these symptoms typical for you (i.e. history of allergies, migraines, other known medical condition that usually causes these symptoms)?

□ YES – Please self-isolate.

Customer Signature: _____

Screener Signature: _____