COVID SCREENING FORM

Name______________ Date____________
Temperature ________(taken upon arrival)

If you answer YES to questions defer treatment and contact 811.

Are you sick or exhibiting any of the following symptoms?
□ Fever (including chills/sweats)
□ Dry cough (new or worsening)
□ Shortness of breath or difficulty breathing
□ Runny nose or congested nose (not related to seasonal allergies or known cause/condition)
□ Sore throat or difficulty swallowing
□ Headache
□ loss of smell or taste
□ Unusual fatigue, lack of energy
□ New onset of muscle aches
□ Loss of appetite
□ Vomiting or diarrhea for more than 24 hours

In the last 14 days, have you been in close contact with a known case of COVID-19? □ Yes □ No

Have you been in close contact with a presumptive or confirmed positive case of COVID-19 or someone isolating? □ Yes □ No

Were you outside of Newfoundland & Labrador in the last 14 days? □ Yes □ No

In the last 14 days, did you have close contact with an ill person who travelled outside of Newfoundland & Labrador? □ Yes □ No

Do you require a COVID-19 test as a result of an advisory from Public Health? (e.g., a flight or a public place connected to a COVID-19 case) □ Yes □ No

In the last 14 days, did you work at or visit a place with a COVID-19 outbreak? □ Yes □ No