QUESTIONNAIRE

Health Questionnaire

Answer each question individually:

1. Do you have any of the following symptoms:
    a. Cold or flu like symptoms?
    b. Fever
    c. Chills
    d. Shortness of breath
    e. Sore throat or painful swallowing
    f. Stuffed up or runny nose
    g. Significant fatigue
    h. Loss of sense of smell
    i. Headache
    j. Muscle aches
    k. Loss of appetite

2. Has anyone in your household had any of the symptoms from question 1?

3. Have you or anyone in your household been outside of Canada in the last 14 days?

4. Have you been in contact with anyone that has been positive for Covid-19 in the last 14 days?

ANYONE ANSWERING YES TO ANY OF THE QUESTIONS SHOULD LEAD TO THE ILLNESS POLICY.