Please complete this questionnaire prior to your visit. This form will be kept in your file.

1. Do you have any of the following symptoms: fever/feverish, new or existing cough and difficulty breathing?

   ☐ YES ☐ NO

2. Have you traveled internationally within the last 14 days (outside Canada)?

   ☐ YES ☐ NO

3. Have you had close contact with a confirmed or probable COVID-19 case?

   ☐ YES ☐ NO

4. Have you had close contact with a person with acute respiratory illness who has been outside Canada in the last 14 days?

   ☐ YES ☐ NO

I certify that I have answered the questions truthfully.

Name:______________________________________

Signed:_____________________________________

Date:_______________________________________

Source – http://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/2019_screening_guidance.pdf

Note – **DO NOT ADD OR ALTER** this document to create a consent form