

GUEST HEALTH CHECK

I, _____ certify the following:

1. I have the following symptoms today (*please check off*)::

- Severe difficulty breathing (e.g. struggling to breathe or speaking in single words);
- Severe chest pain;
- Having a very hard time waking up;
- Feeling confused;
- Losing consciousness;
- Mild to moderate shortness of breath;
- Inability to lie down because of difficulty breathing;
- Chronic health conditions that you are having difficulty managing because of difficulty breathing;
- Fever (in adults and children 38°C or above, in elderly 37.8°C or 1.1°C higher than your usual temperature);
- Cough;
- Sore throat;
- Runny nose that is not allergies;
- Sudden loss of smell without nasal congestion, with or without loss of taste;
- Intense fatigue;
- Severe loss of appetite;
- Diarrhea; or
- Headache.

2. I have travelled outside of Canada in the last 14 days. Yes _ No ___

3. Within the last 14 days I provided care or had close contact* with a symptomatic person known or suspected to have COVID-19.

Yes ___ No__

4. I have had close contact* with a person who travelled outside of Canada in the last 14 days who has become ill with the above-stated symptoms.

Yes __ No __

5. The above is also true for the children in my care. Yes _____ No ___

Dated: _____, 2020

Guest: _____

Guest Signature: _____

* Close Contact is defined as follows:

- a person who provided care for the individual, including healthcare workers, family members or other caregivers, or who had other similar close physical contact with the person without consistent and appropriate use of personal protective equipment; or
- who lived with or otherwise had close prolonged contact (within two metres) with the person while they were infectious; or
- had direct contact with infectious bodily fluids of the person (e.g. was coughed or sneezed on) while not wearing recommended personal protective equipment.