Covid19 Consultant User From

Name:_____ Age:_____

Phone Number (Optional):_____

1. In the last 14 days have you travelled outside of Canada? _____
2. Have you test positive for Covid-19 or had close contact with a confirmed case of COVID-19 without appropriate PPE? _____
3. Have you had any **ONE** of the following symptoms?

   a. Fever _____
   b. Chills _____
   c. Cough _____
   d. Difficulty swolling _____
   e. Digestive issue _____
   f. Headache _____
   g. Lost smell or taste _____
   h. Muscle aches _____
   i. Runny nose _____
   j. Sore Throat _____

COVID-19 RESPONSE

Canada