HEALTH SCREENING QUESTIONNAIRE

Do you have any of the following:

☐Fever ☐Chills ☐New or Worsening Cough

☐Shortness of breath ☐Sore throat ☐New muscle aches or headache

Have you travelled outside of Canada in the last 14 days? ☐Yes ☐No

Are you a close contact of a person who has tested positive for COVID-19? ☐Yes ☐No

SIGNATURE*: ______________________________

**By using my electronic signature, I agree that my electronic signature has the same force and effect as my original handwritten signature would have*

NAME (print): ______________________________

E-Mail/Telephone: ______________________________

ATTENDANCE DATE:____________________ ATTENDANCE TIME: ____________________

VENUE:______________________________ DATE SIGNED:______________________________

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