Name: ______________________________ Date of Birth (mm/dd/yy): ____________

Q1: Did you have close contact with anyone with acute respiratory illness in the past 14 days? Yes No

If **yes**, please tell us when: ______________________________

Q2: Did you travel and/or have close contact with anyone who has traveled outside of Ontario in the past 14 days? Yes No

If **yes**, please tell us when: ______________________________

Q3: Have you been diagnosed with COVID-19 or have been in close contact with someone diagnosed with COVID-19? Yes No

If **yes**, please tell us when: ______________________________

Q4: Do you have any of the following symptoms? If YES, please check the box next to the symptom(s).

Fever
Chest pain
New onset of cough and/or chronic cough
Shortness of breath and/or difficulty breathing
Sore throat and/or difficulty swallowing
Decrease/loss of sense of smell or taste
Chills
Headaches
Nausea and/or vomiting
Diarrhea and/or abdominal pain
Pink eye
Runny nose, sneezing, and/or nasal congestion
Fatigue

If you answered **NO** to **ALL** of the above, please check this box.

If you answered **YES** to having **ANY** of the above, please explain these symptoms and when you began experiencing them: ______________________________

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______________________________ ____________

Patient/Guardian Signature Date signed