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Checklist

COVID-19 Screening Questionnaire

		YES	NO
Do you have any of the following possible symptoms related to COVID-19?	Fever or chills	☐	☐
	Cough or worsening chronic cough	☐	☐
	Difficulty breathing	☐	☐
	Flu like symptoms (headache, sore throat, runny nose)	☐	☐
	Unusual muscle or body aches	☐	☐
	Atypical headache	☐	☐
	New loss of taste or smell	☐	☐
	Nausea or vomiting	☐	☐
	Diarrhea	☐	☐
Have you travelled outside of the province in the last 14 days?		☐	☐
Have you been in contact with someone who is a confirmed case of COVID-19 in the last 14 days?		☐	☐
Have you been advised by your physician or Public Health professional to be in self-isolation (currently or within the last 14 days)?		☐	☐

For more risk control information, please consult an Ecclesiastical Risk Control Specialist in your region or visit **www.ecclesiastical.ca**