Name: _____ Date:_____

BODY ESSENTIALS COVID-19 PRE-SCREENING

Please read each of the questions below; Answering "Yes" or "No". This document can be printed out with your answers indicated in the left margin or can be returned to me by email or text.

1. Have you had close contact with anyone with an acute respiratory disorder ?

2. Have you been in close contact with a confirmed case of Covid19 without wearing appropriate PPE?

3. Have you travelled outside of CANADA in the past 14 days?

4. Fever (temperature of 37.8C or greater)?

5. New cough or worsening chronic cough?

6. Shortness of breath?

7. Sore throat?

8. Runny nose, stuffy nose congestion (*in absence of underlying reasons such as seasonal allergies, post nasal drip, etc*)?

9. Unexplained fatigue, general feeling of being "unwell" or muscle pains?

10. Exacerbation (worsening) of chronic conditions?

11. Chills?

12. Headaches?

13. Decrease or Loss of Taste or Smell?

14. Children under age 18; nausea, vomiting, diarrhea?

15. Have you personally tested positive for Covid19 in the past 10 days or told to self-isolate?

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