COVID-19 Screening and Contact Tracing

1. In the last 5 days have you experienced one or more of the symptoms below? Symptoms should not be chronic or related to other known causes or conditions. Yes ☐ No ☐

   - Fever and/or Chills
   - Cough or Barking Cough
   - Shortness of Breath
   - Sore Throat
   - Extreme Tiredness
   - Muscle Aches/Joint Pain
   - Loss of Taste/Smell
   - Runny or Stuffy Nose
   - Nausea, Vomiting and/or Diarrhea
   - Headache

2. Has a doctor, health care provider, or public health unit told you that you should currently be isolating (staying at home)? Yes ☐ No ☐

3. In the last 5 days, have you tested positive on a rapid antigen test or a home based self-testng kit? Yes ☐ No ☐

4. Do you **live with** someone who is: Yes ☐ No ☐
   - currently isolating because of a positive COVID-19 test
   - currently isolating because of COVID-19 symptoms
   - waiting for COVID-19 test results

5. In the last 14 days, have you travelled outside of Canada **AND** been advised to quarantine per the federal quarantine requirements? Yes ☐ No ☐

Contact Tracing: Please print clearly as the information may be used by Public Health to notify you of a potential exposure to Covid-19.

Event: ______________________________

Name: ______________________________

Phone Number: ______________________________

Date: ______________________________

HTR USE:

Proof of Vaccination: ______________ BIB #: ________

Revision Date: February 7, 2022