



COVID-19 - MANDATORY

Complete the following questions before beginning EACH training session.

Name: _____

Date: _____ Time: _____

Do you have any of the following new or worsening symptoms?



Yes

No

Fever/Chills



Yes

No

Cough



Yes

No

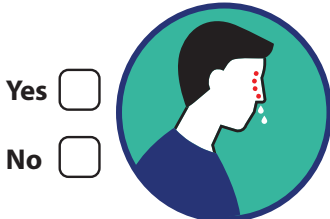
**Difficulty breathing/
Shortness of breath**



Yes

No

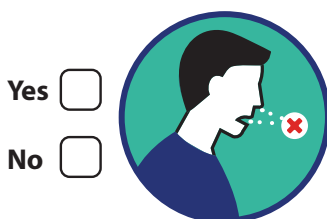
**Sore throat/
Difficulty swallowing**



Yes

No

**Runny nose
(unrelated to
seasonal allergies)**



Yes

No

**Loss of taste
or smell**



Yes

No

**Not feeling well,
headache, unexplained
tiredness and muscle aches**



Yes

No

**Nausea, vomiting,
diarrhea,
abdominal pain**



Yes

No

In the last 14 days, have you had close physical contact with a person who:

- was sick with a respiratory illness (had a new or worsening cough, fever or difficulty breathing)?
- has returned from travel outside of Canada in the last 14 days?
- was a confirmed or probable case of COVID-19?



Yes

No

In the last 14 days, have you travelled outside of Canada?



If you answered **YES** to any of these questions, **please return home and self-isolate**. Visit <https://www.myhealthunit.ca> for more information about getting tested.

If you are feeling unwell, contact your health care provider or call **Telehealth Ontario** at **1-866-797-0000** to speak to a registered nurse.