T.A.R.R. Centre Visitor Covid-19 Self Screening Questions

(please circle yes or no)

1) **Do you have any of the following symptoms:**

   Fever/chills

   Cough

   Difficulty breathing / shortness of breath

   Sore throat / difficulty swallowing

   Runny Nose

   Loss of taste or smell

   Headache, fatigue, muscle aches

   Nausea

   YES NO

2) **In the last 14 days have you had close physical contact with a person who was sick with a respiratory illness?**

   YES NO

3) **In the last 14 days have you had close physical contact with someone who has traveled outside of Canada?**

   YES NO

4) **In the last 14 days have you had contact with a person who was a confirmed or probable case of COVID-19?**

   YES NO

5) **In the last 14 days have you traveled outside of Canada?**

   YES NO

Please return a photo or scanned copy of your completed form to hailey@tarr.mb.ca