COVID-19 SELF-SCREENING

REVIEW THESE QUESTIONS, BEFORE SIGNING IN

1. IF YOU HAVE ANY OF THE FOLLOWING SYMPTOMS (not related to a known diagnosed chronic condition) ***YOU SHOULD ASSUME YOU HAVE COVID AND DO NOT ENTER***:
   - fever or chills (Temperature measures 37.8°C/100.4°F or higher.)
   - cough
   - shortness of breath
   - decreased or loss of taste or smell
   - two or more of:
     - runny nose or nasal congestion
     - sore throat
     - headache
     - extreme fatigue
     - muscle aches or joint pain
     - gastrointestinal symptoms (such as vomiting or diarrhea)

COVID CAN PRESENT AS COLD-LIKE SYMPTOMS.

2. Travelled out of Canada in the past 14 days and had to quarantine per federal requirements? -- IF SO, ***DO NOT ENTER***.

3. Had close contact* with a confirmed or suspected case of COVID in the past 10 days? *Close Contact: means being coughed or sneezed on or being within 2 meters of an individual with any above-listed symptoms for 15 minutes or more. – IF SO, ***DO NOT ENTER.***

4. Has a doctor, health care provider, or public health unit told you to isolate/stay home? – IF SO, ***DO NOT ENTER***.

5. In the last 10 days, have you tested positive on a rapid antigen test or self-testing kit? – IF SO, ***DO NOT ENTER***.
   If you have since tested negative on a lab-based PCR test – answer "NO".

6. ***VACCINATION STATUS:*** Have you had two COVID vaccines more than 14 days ago OR have a valid unexpired medical exemption certificate issued by a licensed physician or nurse practitioner? *If "NO" –you* ***CANNOT ENTER.***

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