

SELF-REPORTING FORM FOR VISITOR OR CAREGIVER COVID-19

Date : _____ Arrival time : _____

Self-reporting form for visitor or caregiver

1. Did you travel outside of Canada in the last 14 days?

NO YES What was your return date? _____

2. Do you come from an institution/a place with a COVID-19 outbreak?

NO YES Which one? _____

3. Did you receive a positive test result for COVID-19 for which containment measures are still in place?

NO YES

4. Did you have a close contact, or was it identified as such by the *Santé Publique*, meaning a contact for more than 15 minutes at less than 2 metres distance, with a person infected or suspected to be infected with the COVID-19 virus?

NO YES

5. Do you have 1 of the following symptoms?

Chills or fever NO YES

Cough (new or exacerbated) NO YES

Breathing difficulties (new or worsened) NO YES

Loss of smell (anosmia) with or without loss of taste (ageusia) NO YES

Sore throat NO YES

Nasal discharge or nasal congestion (of unknown cause) NO YES

Do you have at least 2 of the following symptoms?

Headache NO YES

Muscle pain NO YES

Intense fatigue NO YES

Loss of appetite NO YES

Gastrointestinal symptoms (stomach ache, nausea, vomiting, diarrhea) NO YES

General health deterioration NO YES

Date of onset of symptoms: _____

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6. I confirm that the above-mentioned information is accurate.

Your name as a visitor or a caregiver: _____

The city where you live: _____

Your phone number: _____

The name of the person you are visiting: _____

7. Please give this form back to the designated person at the reception area. This person will let you know the final decision:

The visitor/caregiver cannot get in

The visitor/caregiver can get in

Security guard or receptionist's name : _____

Note: If you answered YES to one or more of the above questions, to protect residents and employees, you cannot have access to the residence.