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| **Visitor Name: ­­­­­­­­­** |
| **Date:** |
| **Visitor Signature:** |
| **Phone Number:**  |
| **Email:** |

1. Are you experiencing any symptoms of COVID-19, including cough, fever or shortness of breath?

**□ Yes □ No**

2. Has anyone you are currently living with experienced any symptoms of COVID-19, including cough, fever or shortness of breath?

 **□ Yes □ No**

3. Have you travelled outside of Canada, including the USA and internationally, in the last 14 days?

**□ Yes □ No**

4. Has anyone you are currently living with travelled outside of Canada, including the USA and internationally, in the last 14 days?

**□ Yes □ No**

5. Have you been in contact with anyone who has tested positive for COVID-19 in the last 14 days?

**□ Yes □ No**

6. Have you been in contact with anyone who has experienced cough, fever or shortness of breath in the last 14 days?

**□ Yes □ No**

Thank you for taking the time to fill out the form!