



SELF-DECLARATION BY VISITOR

To prevent the spread of COVID-19 and reduce the potential risk of exposure to our workforce and visitors, all visitors must complete a simple screening questionnaire. Your participation is important to help us take precautionary measures to protect you and everyone in this facility. Thank you for your time.

1. Have you had close contact with anyone with acute respiratory illness or travelled outside of Ontario in the past 14 days?

Yes No

2. Do you have a confirmed case of COVID-19 or have you had close contact with diagnosed with COVID-19 within the last 14 days?

Yes No

3. Do you have any of the following symptoms:

- | | |
|----------------------------|--|
| a. Fever | b. Decrease or loss of sense of taste of smell |
| c. New onset of cough | d. Chills |
| e. Worsening chronic cough | f. Headaches |
| g. Shortness of breath | h. Unexplained fatigue/malaise/muscle aches (myalgias) |
| i. Difficulty breathing | j. Nausea/vomiting, diarrhea, abdominal pain |
| k. Sore throat | l. Pink eye (conjunctivitis) |
| m. Difficulty swallowing | n. Runny nose/nasal congestion without other known cause |

Yes No

4. If you are 70 years of age or older, are you experiencing any of the following symptoms:

- | | |
|-----------------------------|---|
| a. Delirium | b. Unexplained or increased number of falls |
| c. Acute functional decline | d. Worsening of chronic conditions |

Yes No Under 70 years of age

If you answered “yes” to any of the questions above, access to the facility or site will be denied.

Thank you for your honesty and patience as we navigate these unprecedented times.

Signature: _____

Name (Print): _____

Date: _____