1. **Do you have any of the following new or worsening symptoms or signs?**

   Fever or chills
   Cough
   Difficulty breathing or shortness of breath
   Sore throat or trouble swallowing
   Runny or stuffy nose
   Decrease or loss of taste or smell
   Nausea, vomiting or diarrhea
   Not feeling well, extreme tiredness or sore muscles
   Pink eye or headache

2. **Do you live with someone who has a new COVID-19 symptom or is waiting for COVID-19 test results because they had a symptom?**

3. **Has a doctor, health care provider or public health unit told you that you should currently be isolating (staying home)?**

4. **In the last 14 days, have you had close contact with a confirmed or probable case of COVID-19 without wearing appropriate PPE?**

5. **In the last 14 days, have you travelled outside of Canada?**

If "YES" TO ANY SYMPTOM:

<u>STAY HOME & SELF-ISOLATE + GET TESTED OR CONTACT A HEALTH CARE PROVIDER</u>