Nogdawindamin Family and Community Services

VISITOR COVID SELF- ASSESSMENT

Name of Guest	
Office Location of Office/ Workplace Setting	
Date & Time Self-Assessment Completed	
Date & Time of Visit	
Completed by	

Please complete the following indicating Yes or No to each Question.

Do you have any of the following new or worsening symptoms or signs? Symptoms should not be chronic or relates to other known causes or conditions.

Do you have …	**Yes**	**No**
Fever or chill?		
Difficulty breathing or shortness of breath?		
Cough?		
Runny nose / stuffy nose or nasal congestion?		
Decrease or loss of smell or taste?		
Nausea, vomiting, diarrhea, abdominal pain?		
Nausea, vomiting, diarrhea, abdominal pain?		
Not feeling well, extreme tiredness, sore muscles?		

Travel and Contact

Have you …	**Yes**	**No**
Travelled outside of Canada in the past 14 days?		
Had close contact with a confirmed or probable case of COVID-19?		

Acknowledgement

	Yes	**No**
Are you aware of the recommended and restriction in this community regarding gathering size, hand and respiratory hygiene, and the use of face coverings and masks?		
Do you understand that you are expected to properly don your personal protective equipment and wear it at all times in this setting with exception whey you are eating?		
Do you acknowledge that any time your Personal protective equipment is removed you must maintain a distance of 2 meters or 6 feet from others?		
Does anyone in your household have any symptoms related to COVID-19?		

Please submit completed forms to: assessments@nog.ca