COVID-19 SCREENING FORM

Name: _____ Phone: _____

Address: _____ E-Mail: _____

TRAVEL HISTORY

1. Have you traveled outside of Canada within the past 14 days? ❑ YES ❑ NO If yes then do not continue.

POTENTIAL EXPOSURE

Please answer the following questions as they relate to your potential exposure to COVID-19.

QUESTION	YES	NO
Have you been in close contact, working with, or living with someone with a known or suspected case of COVID-19?	☐	☐
Have you or anyone you work with or living with been tested for COVID-19?	☐	☐
Have you been in contact with people with symptoms of fever, cough, or difficulty breathing?	☐	☐
Do you have any of the following symptoms? Check only those that apply. ❑ Fever | ❑ Cough | ❑ Difficulty Breathing | ❑ Runny Nose | ❑ Sore Throat | ❑ Vomiting ❑ Fatigue | ❑ Loss of Taste/Smell | ❑ Headache | ❑ Muscle or Joint Pain and Chills ❑ Other Symptom/s	☐	☐

Testing for COVID-19 is considered on a case-by-case basis in consultation with local health departments.

_____ reserves the right to restrict entry to the farm for any individuals it feels present a risk of infection. Entry will not be permissible without documentation indicating an absence of infection from an appropriate health care provider, if an individual has tested positive and recovered.

_____	_____	_____
Completed by:	Date	Signature