SINGLE-DAY SYMPTOM QUESTIONNAIRE

Every person attending an in-person meeting must complete and sign the questionnaire below EACH time they attend a meeting. No person will be allowed entrance if they have not completed the questionnaire or if they answered YES to any of the questions.

Symptom Screening Questionnaire

1. Are you currently experiencing any cold, flu or COVID-19-like symptoms, **even mild ones**?

(Symptoms include: Fever, chills, cough or worsening of chronic cough, shortness of breath, sore throat, runny nose, loss of sense of smell or taste, headache, fatigue, diarrhea, loss of appetite, nausea and vomiting, muscle aches. While less common, symptoms can also include: stuffy nose, conjunctivitis (pink eye), dizziness, confusion, abdominal pain, skin rashes or discoloration of fingers or toes)

○ No ○ Yes

2. Have you been in contact with anyone displaying illness, or signs and symptoms of Covid-19?

○ No ○ Yes

3. Have you travelled outside of BC within the past 14 days?

○ No ○ Yes

_____ _____

Print Member Name Date

_____

Signature