COVID-19

SCREENING QUESTIONNAIRE

EeVee Sister's Salon

DATE: TIME:

First Name: _____ Last Name: _____

Phone Number: _____ Email Address: _____

Have you travelled outside of the country in the past 14 days? ◯ Yes ◯ No

Have you been in close contact with someone who has travelled outside of the country in the past 14 days? ◯ Yes ◯ No

Have you been in close contact with someone confirmed/suspected to have, or under investigation for, COVID-19 in the past 14 days? ◯ Yes ◯ No

Are you experiencing any of the following:

	YES	NO
• Fever	☐	☐
• Cough	☐	☐
• Difficulty breathing	☐	☐
• Shortness of breath	☐	☐
• Chills	☐	☐
• Sore throat, trouble swallowing or hoarse voice	☐	☐
• Runny nose or nasal congestion	☐	☐
• Loss of taste or smell	☐	☐
• Headaches	☐	☐
• Fatigue or muscle aches with unknown cause	☐	☐
• Nausea, vomiting, or diarrhea	☐	☐
• Any changes in health not mentioned above	☐	☐

_____

_____

_____

Client was:

☐ Advised that they may proceed with their appointment

☐ Advised to stay or remain at home and reschedule appointment

OFFICE USE ONLY