SHARPE
SOUND
STUDIOS INC.

COVID-19

Please complete the following questions before beginning your work today.

Name: ______________________________

Date: ____________________ Time: ____________________

Do you have any of the following new or worsening symptoms?

Yes ☐ No ☐ **Fever/Chills**

Yes ☐ No ☐ **Cough**

Yes ☐ No ☐ **Difficulty breathing/ Shortness of breath**

Yes ☐ No ☐ **Sore throat/ Difficulty swallowing**

Yes ☐ No ☐ **Runny nose (unrelated to seasonal allergies)**

Yes ☐ No ☐ **Loss of taste or smell**

Yes ☐ No ☐ **Not feeling well, headache, unexplained tiredness and muscle aches**

Yes ☐ No ☐ **Nausea, vomiting, diarrhea, abdominal pain**

Yes ☐ No ☐

In the last 14 days, have you had close physical contact with a person who:

- was sick with a respiratory illness (had a new or worsening cough, fever or difficulty breathing)?
- has returned from travel outside of Canada in the last 14 days?
- was a confirmed or probable case of COVID-19?

Yes ☐ No ☐

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

If you have answered yes to any of these questions it is recommended by the BCCDC you IMMEDIATELY self-isolate and call 8-1-1