

# COVID-19 NOVEL CORONAVIRUS

Please complete the following questions before attending the race today.

Name: \_\_\_\_\_

Date: \_\_\_\_\_ Contact Number: \_\_\_\_\_

## Do you have any of the following:



Fever / Chills



Cough / Croup



Shortness of breath



Sore Throat /  
Difficulty Swallowing



Runny nose /  
Congested nose



Feeling unwell

Yes  Do you have any of the following symptoms: Pink eye, headache,  
No  Loss of taste or smell, Nausea, vomiting, diarrhea, stomach pain,  
Muscle aches, extreme tiredness or falling down often?

Yes  Have you been in close contact with someone who is sick or  
No  has confirmed COVID-19 in the past 14 days?

Yes  Have you been advised to self-isolate or have you returned  
No  from travel outside Canada in the past 14 days?

**If you answered YES to any of these questions, go home & self-isolate right away. Call Telehealth or your health care provider.**

