**Saskatchewan Health Association**

**Daily Screening Check List**

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any of the following symptoms in the past 24 hours:

Fever Yes No

Cough Yes No

Headache Yes No

Muscle and/or joint aches and pains Yes No

Sore Throat Yes No

Chills Yes No

Runny Nose Yes No

Nasal Congestion Yes No

Conjunctivitis (pink eye) Yes No

Dizziness Yes No

Fatigue Yes No

Nausea/Vomiting Yes No

Diarrhea Yes No

Loss of appetite Yes No

Loss of sense of taste or smell Yes No

Shortness of breath Yes No

Difficulty breathing Yes No

If you answered yes to any of the above, do you feel they are Covid – 19 related Yes No

Have you been in contact with anyone that has tested positive for Covid - 19

 Yes No

**Note:**

 To obtain a referral to a community testing center phone 811