PLEASE READ BEFORE CHECKING IN

IF **ALL** ANSWERS ARE NO, PLEASE, CHECK IN AT OUR TABLET AND HAVE A SEAT

IF **ONE OR MORE** ANSWERS IS YES, PLEASE, PUT ON A MASK AND SPEAK TO RECEPTION

COVID-19 SCREENING QUESTIONNAIRE

1. Do you have any of the following symptoms or had any of these symptoms over the last 10 days that are new, worsening and NOT related to other known causes or conditions?

-Fever and/or chills
-Cough or barking cough
-Shortness of breath
-Decrease or loss of taste or smell
-Muscle aches/joint pain
-Abdominal pain
- Extreme tiredness
-Sore throat
-Runny or stuffy/congested nose
-Headache
-Nausea, vomiting and/or diarrhea
- Pink eye

2. Have you **OR** a household member you live with tested positive for Covid-19 in the past 10 days on a laboratory-based PCR test, rapid molecular test, rapid antigen test or other home-based self-testing kit?

3. Have you been told (by a doctor, health care provider, public health unit, border agent, or any other government authority) that you should be quarantining, isolating or staying home?

4. Are you immunocompromised?

****Please, report if you develop Covid-19 within 10 days after your appointment to 905-878-8865 or info@miltonorthodontics.ca ****