BBW Staff Health Screening Questionnaire

Please complete the following questions before beginning your work today.

Name: _____

Date: _____ **Time:** _____ ○ AM ○ PM

mm/dd/yyyy

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

	Yes	No
New or worsening cough	○	○
Shortness of breath	○	○
Sore Throat	○	○
Runny nose, sneezing or nasal congestion (in absence of underlying reasons for symptoms such as seasonal allergies and post nasal drip)	○	○
Hoarse Voice	○	○
Difficulty Swallowing	○	○
Loss of sense of smell or taste	○	○
Nausea, vomiting, diarrhea, or abdominable pain	○	○
Unexplained fatigue/malaise	○	○
Chills	○	○
Headache	○	○

2. Have you travelled outside of Canada or had close contact with anyone that has travelled outside of Canada in the past 14 days?

○ Yes ○ No

3. Do you have a fever?

○ Yes ○ No

4. Have you had close contact with anyone with respiratory illness or a confirmed or probable case of COVID-19 in the last 14 days?

○ Yes ○ No

Submit your completed form by saving it as a PDF and emailing it as an attachemnt to :

scheduler@bbwinternational.com