Date:_____

Daily Self-Assessment Sheet

Print Name	Company	Are you experiencing any of the following: • Severe difficulty breathing (e.g. struggling to breathe or speaking in single words) • Severe chest pain • Having a very hard time waking up • Feeling confused • Losing consciousness	Are you experiencing any of the following: • Mild to moderate shortness of breath • Inability to lie down because of difficulty breathing • Chronic health conditions that you are having difficulty managing because of difficulty breathing	Are you experiencing any of the following: • Fever • Cough • Sneezing • Sore throat	Have you travelled to any countries outside Canada (including the United States) within the last 14 days?	Did you provide care or have close contact with a person with COVID-19 (probable or confirmed) while they were ill (cough, fever, sneezing, or sore throat)?	Did you have close contact with a person who travelled outside of Canada in the last 14 days who has become ill (cough, fever, sneezing, or sore throat)?	Signature
		□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	
		□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	
		□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	
		□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	
		□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	
		□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	
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		□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	