ON-SITE SCREENING FORM

The answer to **ALL** questions must be '**NO"** in order to participate. Check Boxes if **'NO'**

DATE: _____ **TIME:** _____ **EVENT SESSION:** _____

	Name (all attending participants)	Fever	Cough	Breathing Difficulties	Sore Throat	Difficulty Swallowing	Lost of smell or taste	Feeling unwell	Nausea / Vomiting	Headache	Travelled outside Nunavut in last 14 days	Contact with someone who is being investigated for Covid-19 in last 14 days
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