## COVID-19

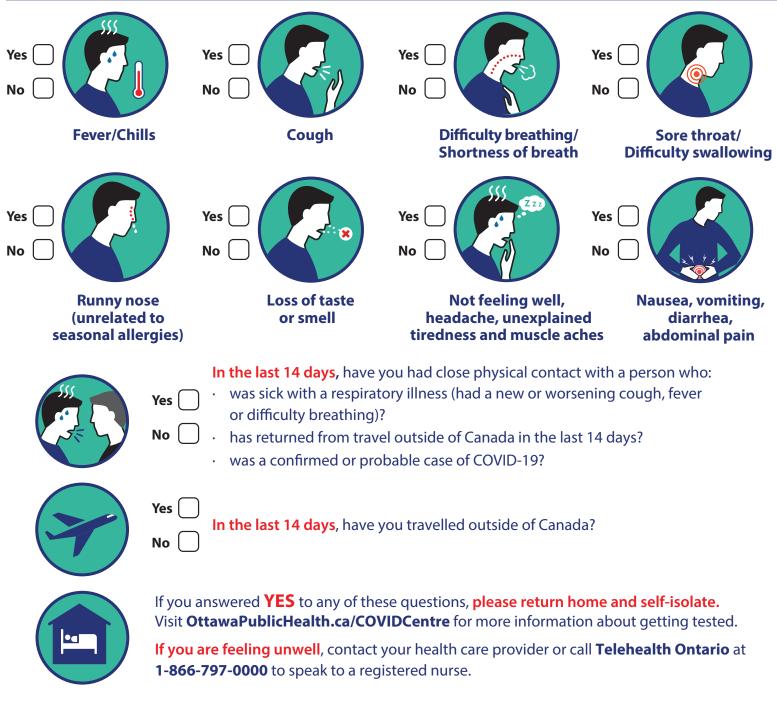
Please complete the following questions before beginning your work today.

## Name:

Date: \_

\_\_\_\_\_ Time: \_\_\_

## Do you have any of the following new or worsening symptoms?



Adapted with permission from Toronto Public Health

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## OttawaPublicHealth.ca/Coronavirus

