Name of institution: CMU College of Makeup Art & Design



Required Screening Questions

Signature: Day Month Year					
Phone Number: Reason for Visit:					
Last Name: Time of Arrival: Time of Departure:					
First name:	Email Add	ress:			
should be advised that they should partially outdoor, workplaces). They soontact their health care provider or need a COVID-19 test.	should go home	e to self	isolate imm	ediat	ely and
If the individual answers YES to any c	questions from	1 throu	gh 3, they ha	ave no	ot passed and
 If the individual answers NO to all quenter the workplace. 	estions from 1	througl	h 3, they hav	e pas	sed and can
Results of Screening Questions:					
Have you had close contact wi □ Yes	th a confirmed (able case of No	COVI	D-19?
2. Have you travelled outside of Canada in the past 14 days? ☐ Yes ☐ No					
Not feeling well, extreme tiredness, sore muscles			Yes		No
Nausea, vomiting, diarrhea, abdominal pain			Yes		No
Decrease or loss of smell or taste			Yes		No
Runny nose/stuffy nose or nasal congestion			Yes		No
Sore throat, trouble swallowing			Yes		No
Cough			Yes		No
Difficulty breathing or shortness of breath			Yes		No
Fever or chills			Yes		No

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

should not be chronic or related to other known causes or conditions.