	Covid-19 Questionnaire	No.	FRM-ADM-010	Page	1 de 1
		Révision	1	Date d'application	14/5/2020

Name

Date

Do you have?

Yes	No	
		Received a positive COVID-19 diagnosis
		Cough
		Sore throat
		Shortness of breath
		Difficulty breathing
		Fever
		Loss of smell / taste
		Traveled less than 14 days ago
		Been in contact with someone with symptoms / COVID-19 positive

Signature