



OCBSA FACILITIES COVID-19 SCREENING

PLEASE READ EACH QUESTION CAREFULLY	PLEASE CIRCLE THE ANSWER THAT APPLIES TO YOU	
<p>Have you experienced any of the following symptoms in the past 48 hours:</p> <ul style="list-style-type: none"> • fever or chills • cough • shortness of breath or difficulty breathing • fatigue • muscle or body aches • headache • new loss of taste or smell • sore throat • congestion or runny nose • nausea or vomiting • diarrhea 	YES	NO
<p>Within the past 14 days, have you been in close physical contact (6 feet or closer for at least 15 minutes) with a person who is known to have laboratory-confirmed COVID-19 or with anyone who has any symptoms consistent with COVID-19?</p>	YES	NO
<p>Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?</p>	YES	NO
<p>Are you currently waiting on the results of a COVID-19 test?</p>	YES	NO

<p>Did you answer NO to ALL QUESTIONS?</p>	<p>Access to OCBSA facilities APPROVED. Thank you for helping us protect you and others during this time.</p>
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<p>Did you answer YES to ANY QUESTION?</p>	<p>Access to OCBSA facilities NOT APPROVED. Thank you for helping us protect you and others during this time.</p>
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