COVID-19 Screening Questions

Please screen yourself by answering the below questions:

1

Do you have any of the following symptoms?

Fever

New or worsening cough, or shortness of breath

Headache

Diarrhea, nausea, vomiting

Sore throat

2

Have you or anyone in your household had a positive COVID-19 test in the last 10 days?

3

Are you a close contact of someone who has tested positive for COVID-19?

STOP

If you answered YES to any of the questions, we ask that you leave and return when you are well.

St. Joseph's Healthcare Hamilton