CVH (No. 8) LP
200 Robert Street
Shelburne, ON L9V 3S1

T 519-925-3746
F 1-888-207-0031
www.shelburneltc.ca

Shelburne: Visitor Self-Screening Form

Name: _____

Name of Resident Visiting: _____

1. Do you have a fever (temperature of 37.8C or greater)? ☐ Yes ☐ No

2. Are you experiencing ANY of the following symptoms?

New or worsening cough	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Sore throat	☐ Yes	☐ No
Runny nose or sneezing	☐ Yes	☐ No
Nasal congestion	☐ Yes	☐ No
Hoarse voice	☐ Yes	☐ No
Difficulty swallowing	☐ Yes	☐ No
New smell or taste disorder(s)	☐ Yes	☐ No
Nausea/vomiting, diarrhea, abdominal pain	☐ Yes	☐ No
Unexplained fatigue/malaise	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Headache	☐ Yes	☐ No

3. Have you travelled or had close contact with anyone that has travelled outside of Canada in the past 14 days? ☐ Yes ☐ No

4. Have you had close contact with anyone with respiratory illness or a confirmed or probable case of COVID-19? ☐ Yes ☐ No

☐ **By checking this box, I confirm that I have tested negative for COVID-19 within the previous 2 weeks and have not since tested positive.**

If you answered "yes" to any of the questions 1 to 4 or cannot confirm a negative COVID-19 test result, please contact the home to reschedule your outdoor visit.