COVID-19 Student & Staff Health Questionnaire

1. Name: _____

2. Date/Time: _____

3. Do you have respiratory symptoms such as congestion, cough or shortness of breath?
   _____ Yes (notify Academy Coordinator or RTO) _____ No (proceed to #4)
   *If yes to 3 or 4, a mask shall be donned, isolate yourself away from others, do not touch anything at the facility, go home and notify your doctor immediately. Those staff assisting and performing assessment should be in PPE. Staff to document.

4. Have you had close contact with a person infected with COVID-19?
   _____ Yes (notify Academy Coordinator or RTO) _____ No
   *If yes for #4, additional information will be gathered for a case by case determination of appropriate actions by the Academy staff.

I certify that the above is true and correct. Signature:_____ Print:_____