**Contact Tracing Sign-In Sheet**

**By signing my name below, I attest that my response to the following questions is “no”.**

1. Are you experiencing any cold or flu-like symptoms (cough, fever, runny nose, sore throat, shortness of breath, loss of taste or smell, conjunctivitis, fatigue, headache, vomiting or diarrhea, muscle aches, skin rash, nausea)?
2. In the last 14 days, have you been in contact with someone who is confirmed to have COVID-19?
3. Have you been in a setting in the last 14 days that has been identified as a risk for acquiring COVID-19, such as on a flight, at a workplace, or at an event?
4. Have you travelled outside of Western Canada in the last 14 days?

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| **Name** | **Signature** | **Phone Number** | **Email** |
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