

Pre-screening Health Declaration Form (COVID-19) – Visitor and Students



Angie's Foot Care

Name:

Phone number:

Please complete this form each time prior your appointment/ clinical. Following the successful completion of this form, you may be required to complete a temperature check prior entering the clinic.

In the last 14 days, have you been in close contact with anyone that is experiencing symptoms associated with COVID 19, or someone with a known or probably case of COVID 19?

Yes

No

Have you travelled outside the province or have you been in close contact with anyone who has travelled outside the province in the past 14 days?

Yes

No

Do you have any Fever or chills; Difficulty breathing or shortness of breath; Cough; Severe chest pain; Pink eye; Sore throat, trouble swallowing; Runny or stuffy nose or nasal congestion; Decrease or loss of smell or taste; Nausea, vomiting, diarrhea, abdominal pain; Feeling weak, extreme tiredness, sore muscles; Trouble waking up; Loss of consciousness; Feeling confused; Skin rash; or Discolouration of fingers or toes.

Yes

No

If you answered, "yes" to any of the above questions, you are not permitted to enter the clinic. If you answered "no" to all of the above questions, you may proceed into the clinic. If you begin to experience symptoms, please report this to us immediately. This is a reminder to adhere to the safe distancing rules, wear your required personal protective equipment, and practice safe hygiene.

Confirmation I, the undersigned, confirm that I have completed this form in good faith and certify that all information in this form is true and correct to the best of my knowledge. I understand that entering the facility when I have been potentially exposed to COVID-19 poses a grave risk to the health and wellness of others.

Signature:

Date: