

**COVID-19 Active Screening: Patient / Designated Support Person / Visitor  
Access to Facilities**

1. Do you have **ONE** of the below symptoms?

- FEVER/SIGNS OF FEVER (e.g., chills, feeling cold, shivers, etc...)
- LOSS OF TASTE
- LOSS OF SMELL

**OR**

Do you have any **TWO** the below symptoms?

- NEW COUGH OR A COUGH THAT IS GETTING WORSE
- SHORTNESS OF BREATH
- SORE THROAT
- RUNNY NOSE/NASAL CONGESTION
- HEADACHE
- DIARRHEA
- LOSS OF APPETITE
- NEW ONSET OF MYALGIA (muscle pain)
- NEW ONSET OF FATIGUE
- PURPLE MARKINGS ON FINGERS OR TOES (for children)

2. Have you had close contact with a confirmed case of COVID-19 in the last 10 days?

3. Have you tested positive for COVID-19 within the past 10 days?

4. Have you travelled outside of Canada or the State of Maine in the last 10 days?