WALES YOUNG INSTITUTE

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Covid-19 Assessment Survey

Name:	
Student ID (If applicable) :	
DATE (DD/MM/YYY):	

Instructions:

Note that this survey is intended for COVID-19 use only. Answer all the questions to the best of your ability. If you answer yes to any of the following questions, it is recommended that you stay at home and contact a practitioner or call 8-1-1.

1. Are you experiencing any of the following:

    1. Severe difficulty breathing 9e.g. struggling to breathe or speaking in singe words)
    2. Severe chest pain
    3. Having a very hard time waking up
    4. Feeling confused
    5. Losing consciousness

    - Yes
    - No

2. Are you experiencing any of the following:

    1. Mild to moderate shortness of breath.
    2. Inability to lie down because of difficult breathing
    3. Chronic health conditions that you are having difficulty managing because of difficulty breathing

    - Yes
    - No

3. Are you experiencing cold, flu, or COVID-19 symptoms, **even mild ones?**

- Yes
- No

4. Have you traveled to any countries outside Canada within the last 14 days?

- Yes
- No

5. Did you provide care or have close contact with a person with confirmed COVID-19?

- Yes
- No