COVID19 Screening Questions

Name: _____ Date: _____

1. Do you have any of the following new or worsening symptoms or signs?

New or worsening cough	○ Yes	○ No
Shortness of breath	○ Yes	○ No
Sore throat	○ Yes	○ No
Runny nose, sneezing, or nasal congestion (in the absence of underlying reasons such as seasonal allergies or post nasal drip)	○ Yes	○ No
Hoarse voice	○ Yes	○ No
Difficulty swallowing	○ Yes	○ No
New smell or taste disorder(s)	○ Yes	○ No
Nausea/vomiting, diarrhea, abdominal pain	○ Yes	○ No
Unexplained malaise/fatigue (tired)	○ Yes	○ No
Chills	○ Yes	○ No
Headache	○ Yes	○ No

2. Have you traveled outside of Canada or had close contact with anyone that has traveled outside of Canada in the past 14 days?

○ Yes ○ No

3. Do you have a fever?

○ Yes ○ No

4. Have you had close contact with anyone with a respiratory illness or a confirmed OR probable case of COVID19?

○ Yes – Go to Question #5 ○ No – Screening Complete

5. Did you wear the required and/or recommended PPE according to the types of duties you were performing (e.g., goggles, gloves, mask and gown, etc) when you had close contact with a suspected or confirmed case of COVID19?

○ Yes ○ No

NO to all questions from 1 through 4 = **Enter**
YES to any questions from 1 through 3 = Do Not Enter. Wash hands, wear mask, call 811
YES to Question #4 and Question #5 = **Enter**
YES to Question #4 and **NO** to Question #5 = Do Not Enter. Wash hands, wear mask, 811.