Required Screening Questions

Name: ___________________________________ **Phone #**: __________________ **Date:** _________________

1. Are you currently experiencing one or more of the symptoms below that are new or worsening? Symptoms should not be chronic or related to other known causes or conditions.

Do you have one or more of the following symptoms?	☐ **Yes**	☐ **No**
Fever and/or chills	Temperature of 37.8 degrees Celsius/100 degrees Fahrenheit or higher	
Cough or barking cough (croup)	Not related to asthma, post-infectious reactive airways, COPD, or other known causes or conditions you already have.	
Shortness of breath	Not related to asthma or other known causes or conditions you already have	
Sore throat	Not related to seasonal allergies, acid reflux, or other known causes or conditions you already have	
Difficulty swallowing	Painful swallowing (not related to other known causes or conditions you already have)	
Decrease or loss of smell or taste	Not related to seasonal allergies, neurological disorders, or other known causes or conditions you already have	
Pink eye	Conjunctivitis (not related to reoccurring styes or other known causes or conditions you already have)	
Runny or stuffy/congested nose	Not related to seasonal allergies, being outside in cold weather, or other known causes or conditions you already have	
Headache	Unusual, long-lasting (not related to tension-type headaches, chronic migraines, or other known causes or conditions you already have)	
Digestive issues like nausea/vomiting, diarrhea, stomach pain	Not related to irritable bowel syndrome, menstrual cramps, or other known causes or conditions you already have	
Muscle aches	Unusual, long-lasting (not related to a sudden injury, fibromyalgia, or other known causes or conditions you already have)	
Extreme tiredness	Unusual, fatigue, lack of energy (not related to depression, insomnia, thyroid dysfunction, or other known causes or conditions you already have)	

2. Has a doctor, health care provider, or public health unit told you that you should currently be isolating (staying at home)?

☐ Yes ☐ No

3. In the last 14 days, have you been identified as a "close contact" of someone who currently has COVID-19?

☐ Yes ☐ No

4. In the last 14 days, have you received a COVID Alert exposure notification on your cell phone?
If you already went for a test and got a negative result, select "No."

☐ Yes ☐ No

5. In the last 14 days, have you or anyone you live with travelled outside of Canada? If you or anyone you live with are exempted from federal quarantine as per Group Exemptions, Quarantine Requirements under the *Quarantine Act*, select "No".

☐ Yes ☐ No