

COVID-19 Screening Questionnaire

Public Health - Contact Tracing Information

This information will only be used by Public Health officials for contact tracing. All information will be disposed of in 30 days.

Name: _____
Contact Number/Email Address: _____
Date: _____
Buildings Accessed: _____

Screening Questions:

1. Do you have any of the following new or worsening symptoms or signs? *Symptoms should not be chronic or related to other known causes or conditions.*

Fever or chills	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Difficulty breathing or shortness of breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sore throat, trouble swallowing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Runny nose/stuffy nose or nasal congestion	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Decrease or loss of smell or taste	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nausea, vomiting, diarrhea, abdominal pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Not feeling well, extreme tiredness, sore muscles	<input type="checkbox"/> Yes	<input type="checkbox"/> No

2. Have you travelled outside of Canada in the past 14 days?

Yes No

3. Have you had close contact with a confirmed or probable case of COVID-19?

Yes No

If you have answered NO to all questions from 1 through 3 then you have passed the screening and can enter the workplace.

If you have answered YES to any questions from 1 through 3 then you have NOT passed the screening and are advised you are unable to enter the workplace (including any outdoor or partially outdoor workspaces). Please go home immediately and contact your health care provider or Telehealth Ontario (1-866-797-0000) to find out if you need a COVID-19 test.