**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: ________________________________

Building(s) 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 and/or chills** - temperature of 37.8 degrees Celsius/100 degrees Fahrenheit or higher

  - □ Yes □ No

- **Cough or barking cough (croup)** - continuous, more than usual, making a whistling noise when breathing, not related to other known causes or conditions (for example, asthma, post-infectious reactive airways, COPD)

  - □ Yes □ No

- **Shortness of breath** - out of breath, unable to breathe deeply, not related to other known causes or conditions (for example, asthma)

  - □ Yes □ No

- **Decrease or loss of smell or taste** - not related to other known causes or conditions (for example, allergies, neurological disorders)

  - □ Yes □ No

- **Sore throat** - Not related to other known causes or conditions (for example, seasonal allergies, acid reflux)

  - □ Yes □ No

- **Difficulty swallowing** - Painful swallowing, not related to other known causes or conditions

  - □ Yes □ No

- **Pink eye** - Conjunctivitis, not related to other known causes or conditions (for example, reoccurring styes)

  - □ Yes □ No

- **Runny or stuffy/congested** - Not related to other known causes or conditions (for example, seasonal allergies, being outside in cold weather)

  - □ Yes □ No

- **Headache that is unusual or long lasting** - Not related to other known causes or conditions (for example, tension-type headaches, chronic migraines)

  - □ Yes □ No

- **Digestive issues like nausea/vomiting, diarrhea, stomach pain** - Not related to other known causes or conditions (for example, irritable bowel syndrome, menstrual cramps)

  - □ Yes □ No

- **Muscle aches that are unusual or long lasting** - Not related to other known causes or conditions (for example, a sudden injury, fibromyalgia)

  - □ Yes □ No

- **Extreme tiredness that is unusual** - Fatigue, lack of energy, not related to other known causes or conditions (for example, depression, insomnia, thyroid dysfunction)

  - □ Yes □ No

- **Falling down often** (older adults)

  - □ Yes □ No
2. Have you travelled outside of Canada in the past 14 days?
   □ Yes □ No

3. In the last 14 days, have you been identified as a close contact of someone who currently has
   COVID-19? Close physical contact means any of the following, without a medical/surgical mask:
   a. being less than 2 metres away in the same room, workspace, or area for 15 minutes or
      more
   b. living in the same home
   □ Yes □ No

4. Has a doctor, health care provider, or public health unit told you that you should currently be
   isolating (staying at home)?
   □ Yes □ No

5. Does anyone in your household have COVID-19 symptoms or is anyone in your household
   waiting for test results after experiencing symptoms?
   □ Yes □ No

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

If you have answered NO to all questions from 1 through 6 then you have passed the screening
and can enter the workplace.

If you have answered YES to any questions from 1 through 6 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.