

### Required 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 checked="" 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

### Results of Screening Questions:

- If the individual answers **NO to all questions from 1 through 3**, they have passed and can enter the workplace.
- If the individual answers **YES to any questions from 1 through 3**, they have not passed and **should be advised that they should not** enter the workplace (including any outdoor, or partially outdoor, workplaces). They should go home to self-isolate immediately and contact their health care provider or Telehealth Ontario (1 866-797-0000) to find out if they need a COVID-19 test.

NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_