COVID-19 Screening Tool for Staff

First Name: _____ Telephone: _____

Last Name: _____

Yes	No	Question
		Are you experiencing ONE or more of the following symptoms, not related to an underlying medical condition: - A fever of 37.8 degrees Celsius or above - A new or worsening cough - Difficulty breathing - Difficulty swallowing - Sore throat - Runny nose - Chills - New gastrointestinal symptoms (e.g. nausea, vomiting, diarrhea, and/or abdominal pain) - Muscle aches - Fatigue - Headache - New smell or taste disorder(s) - Pink eye
		Did you travel outside of Canada in the last 14 days?
		In the last 14 days, have you or someone in your residence had a positive COVID-19 test?
		In the last 14 days, have you been identified as a "close contact" of someone who currently has COVID-19? This includes getting a COVID Alert exposure notification.
		In the last 14 days, have you been in close physical contact with someone who has symptoms compatible with COVID-19 **AND** that person has a. Been identified as a close contact of a confirmed COVID 19 case **OR** b. Attended a school or workplace experiencing an outbreak **OR** c. Travelled to an affected area outside Canada in the 14 days prior to symptom onset.

I confirm that the information given in this form is true, complete and accurate.

Signature: _____ Date: _____ Time: _____

If you answered yes to any of the above questions, **DO NOT** come in to work. Contact your supervisor, centralized scheduling, and the employee health department at ext. 2502