

NAME:  
DATE:

PHONE:  
EMAIL:

## Required Screening Questions

For individuals who are 18 years of age and older

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

<b>Fever and/or chills</b>	Temperature of 37.8 degrees Celsius/100 degrees Fahrenheit or higher
<b>Cough or barking cough (croup)</b>	Not related to asthma, post-infectious reactive airways, COPD, or other known causes or conditions you already have
<b>Shortness of Breath</b>	Not related to asthma or other known causes or conditions you already have
<b>Sore Throat</b>	Not related to seasonal allergies, acid reflux, or other known causes or conditions you already have
<b>Difficulty swallowing</b>	Painful swallowing not related to other known causes or conditions you already have
<b>Decrease or loss of smell or taste</b>	Not related to seasonal allergies, neurological disorders, or other known causes or conditions you already have
<b>Pink eye</b>	Conjunctivitis (not related to reoccurring styes or other known causes or conditions you already have)
<b>Runny or stuffy/congested nose</b>	Not related to seasonal allergies, being outside in cold weather, or other known causes or conditions you already have
<b>Headache</b>	Unusual, long-lasting (not related to tension-type headaches, chronic migraines, or other known causes or conditions you already have) <i>If you received a COVID-19 vaccination in the last 48 hours and are experiencing a mild headache that only began after vaccination, select "No."</i>
<b>Digestive issues like nausea/vomiting, diarrhea, stomach pain</b>	Not related to irritable bowel syndrome, menstrual cramps, or other known causes or conditions you already have
<b>Muscle aches/joint pain</b>	Unusual, long-lasting (not related to a sudden injury, fibromyalgia, or other known causes or conditions you already have) <i>If you received a COVID-19 vaccination in the last 48 hours and are experiencing mild muscle aches/joint pain that only began after vaccination, select "No."</i>
<b>Fatigue</b>	Unusual tiredness, lack of energy (not related to depression, insomnia, thyroid dysfunction, or other known causes or conditions you already have) <i>If you received a COVID-19 vaccination in the last 48 hours and are experiencing mild fatigue that only began after vaccination, select "No."</i>
<b>Falling down often</b>	For older people

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

This can be because of an outbreak or contact tracing, or after testing positive on a rapid antigen test.

- 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 travelled outside of Canada?**

If you are exempted from federal quarantine as per [Group Exemptions, Quarantine Requirements](#) under the *Quarantine Act*, select “No”

- Yes       No

**6. Is anyone you live with currently experiencing any new COVID-19 symptoms and/or waiting for test results after experiencing symptoms?**

- Yes       No

*If the individual experiencing symptoms received a COVID-19 vaccination in the last 48 hours and is experiencing mild headache, fatigue, muscle aches, and/or joint pain that only began after vaccination, select “No.”*

**Results of Screening Questions:**

- If you answered **NO to all questions from 1 through 6**, you can enter the workplace.
- If you answered **YES to any questions from 1 through 6**, you must not enter the workplace (including any outdoor or partially outdoor, workplace). You should inform your employer of this result and go or stay home to self-isolate immediately and contact your health care provider or Telehealth Ontario (1-866-797-0000) to get advice or an assessment, including if you need a COVID-19 test.
- If you answered **YES to question 6**, you must stay home, along with the rest of the household, until the sick individual gets a negative COVID-19 test result, is cleared by their local public health unit, or is diagnosed with another illness.
- If any of the answers to these screening questions change during the day, you should inform your employer of the change and go home to self-isolate immediately and contact your health care provider or Telehealth Ontario (1-866-797-0000) to get advice or an assessment, including if you need a COVID-19 test.
- Businesses and organizations must maintain a record of the date/time that workers were in the workplace and their contact information. This information may be requested by public health for contact tracing. These records should be maintained for a period of at least a month.

Any record created as part of worker screening may only be disclosed as required by law.