COVID-19 SCREENING QUESTIONS

1. Do you have any of the following symptoms or signs?

New or worsening cough?	YES	NO
Shortness of breath?	YES	NO
Sore throat?	YES	NO
Runny nose or sneezing?	YES	NO
Nasal Congestion?	YES	NO
Hoarse voice?	YES	NO
Difficulty swallowing?	YES	NO
New smell or taste disorder(s)?	YES	NO
Nausea/vomiting, diarrhea, abdominal pain?	YES	NO
Unexplained faitigue/malaise?	YES	NO
Chills?	YES	NO
Conjunctivitus?	YES	NO
Headache?	YES	NO

2. Have you travelled or had close contact with anyone that has travelled Internationally in the past 14 days? YES NO

3. Have you had contact with someone who has had exposure to anyone who is being tested or has been confirmed to be a case of COVID-19 that was not wearing the appropriate PPE (personal protective equipment) according to the duties they were performing? (This is second degree exposure). YES NO

4. Have you had close contact or exposure with anyone with a respiratory illness or a confirmed or probable case of COVID-19? YES NO

Please have the Professional Safety Compliance Officer take your temperature, record it below and answer the question.

TEMPERATURE: _____

*NOTE: A temperature of 37.8C or greater (100F) is considered a fever.

5. Do you have a fever? YES NO

NAME (Printed) _____

SIGNATURE _____

CONTACT NUMBER _____

DATE _____

TIME _____

PROJECT _____