COVID-19 Screening Questionaire

PLEASE ENSURE TO COMPLETE SELF SCREENING DAILY

1. Have you or anyone in your house had any close contact with anyone with acute respiratory illness?
   ☐ Yes ☐ No

2. Have you, or anyone in your house travelled outside of Ontario in the past 14 days?
   ☐ Yes ☐ No

Do you have any of the following:

- ☐ Fever (temperature of 37.8°C or greater)
- ☐ New or worsening cough
- ☐ Shortness of breath/difficulty breathing
- ☐ Sore throat or difficulty swallowing
- ☐ Decrease of sense of taste or smell
- ☐ Nausea/vomiting, diarrhea, abdominal pain
- ☐ Runny nose or nasal congestion with out other know cause
- ☐ Unexplained fatigue/malaise/myalgias (muscle aches)
- ☐ Delirium (acutely altered mental status and inattention)
- ☐ Unexplained or increased number of falls
- ☐ Acute functional decline
- ☐ Worsening of chronic conditions
- ☐ Chills
- ☐ Headaches
- ☐ Croup
- ☐ Conjunctivitis (pink eye)
- ☐ Hoarse voice