

# COVID-19 SCREENING TOOL FOR THE WORKPLACE.

## DO YOU HAVE ANY OF THE FOLLOWING...

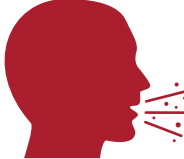
*\* If you have an existing health condition that gives you the symptoms you should not answer YES, unless the symptom is new, different or getting worse. Look for changes from your normal symptoms.*

YES  
 NO



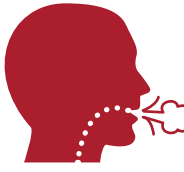
Fever or chills

YES  
 NO



Cough

YES  
 NO



Difficulty Breathing, shortness of breath

YES  
 NO



Sore throat, trouble swallowing

YES  
 NO



Runny/stuffy nose

YES  
 NO




Decreased or loss of taste or smell

YES  
 NO

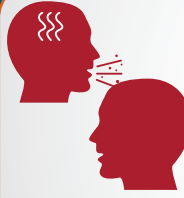


Nausea, vomiting, diarrhea

YES  
 NO




Not feeling well extreme tiredness, sore muscles



Have you had close contact with a confirmed or probable case of COVID-19 without wearing appropriate PPE?

YES  
 NO



Have you travelled outside of Canada in the past 14 days?

YES  
 NO

Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_  
DD/MM/YYYY



**If you answered YES to any of these questions, go home and self-isolate. Call Telehealth or your health care provider, to find out if you need a test.**

**If you answered NO to all of these questions, you have passed and can go to work/attend your activity.**

**These questions are used to screen for COVID-19 before entry into a workplace (business or organization).**