**COVID-19 SCREENING CHECK SHEET**

**To be completed Prior to Entering ZRCC**

**A separate Form for everyone must be completed**

**Visit Date: _____ Day: _____ Time: _____am / pm**

## Screening Questions:

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

| | YES | NO |
|---|---|---|
| **New or worsening cough** | | |
| **Shortness of breath** | | |
| **Sore throat** | | |
| **Runny nose, sneezing or nasal congestion** (in absence of underlying reasons for symptoms such as seasonal allergies and postnasal drip) | | |
| **Hoarse voice** | | |
| **Difficulty swallowing** | | |
| **New smell or taste disorder(s)** | | |
| **Nausea/vomiting, diarrhea, abdominal pain** | | |
| **Unexplained fatigue/malaise** | | |
| **Chills Nausea/vomiting, diarrhea, abdominal pain** | | |
| **Headaches** | | |

2. Have you travelled outside of Canada or had close contact with anyone that has travelled outside of Canada in the past 14 days? **Yes: _____** **No: _____**

3. Do you have a fever? **Yes: _____** **No: _____**

4. Have you had close contact with anyone with respiratory illness or a confirmed or probable case of COVID-19?

   **Yes: _____ – go to question 5** **No: _____ – go to question 6**

5. Did you wear the required and/or recommended PPE according to the type of duties you were performing (e.g., goggles, gloves, mask and gown or N95 with aerosol generating medical procedures (AGMPs)) when you had close contact with a suspected or confirmed case of COVID-19?

   **Yes: _____ – go to question 6** **No: _____**

6. Are you aware of any COVID-19 related reason why you should not be here?

   **Yes: _____** **No: _____ screening complete**

**PRINT NAME: _____ SIGNATURE: _____**

***(a parent or guardian must sign on behalf of children 19 years and under)***