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COVID-19 Screening Form

DATE: _____

PATIENT NAME: _____

1. **Are you fully vaccinated? ie - Did you receive a second vaccination dose more than 14 days ago**? (Note that at this time, all those under 12 years of age should answer "no" to this question).

☐ Yes
☐ No

2. Do you have any of the following symptoms?

☐ Fever and/or chills

☐ New onset cough
☐ Worsening chronic cough
☐ Shortness of breath
☐ Decrease or loss of sense of taste or smell
☐ If 18 years of age or older - Unexplained fatigue/malaise/muscle pain (myalgia)
☐ If under 18 years of age - Nausea/vomiting, diarrhea, abdominal pain

☐ None of the above

3. Have you tested positive for Covid-19 in the past 10 days or have you been told you should be isolating?

☐ Yes
☐ No

Answer the following only if you answered “no” to question 1 (you are not fully vaccinated):

4. Have you travelled outside of Canada in the last 14 days?

☐ Yes
☐ No

5. Have you had close contact with a confirmed case of Covid-19 without wearing appropriate PPE?

☐ Yes
☐ No