

Required Screening Questions

1. Do you have any of the following **new or worsening** symptoms or signs? *Symptoms should not be chronic or related to other known causes or conditions.*

- | | | |
|---|------------------------------|-----------------------------|
| Fever or chills | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Difficulty breathing or shortness of breath | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cough | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sore throat, trouble swallowing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Runny nose/stuffy nose or nasal congestion | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Decrease or loss of smell or taste | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Nausea, vomiting, diarrhea, abdominal pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Not feeling well, extreme tiredness, sore muscles | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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

- Yes No

3. Have you had close contact with a confirmed or probable case of COVID-19?

- Yes No

Results of Screening Questions:

- If the individual answers **NO to all questions from 1 through 3**, they have passed and can enter the workplace
- If the individual answers **YES to any questions from 1 through 3**, they have not passed and **should be advised that they should not** enter the workplace (including any outdoor, or partially outdoor, workplaces). They should go home to self-isolate immediately and contact their health care provider or Telehealth Ontario (1 866-797-0000) to find out if they need a COVID-19 test.