COVID-19 ACTIVE SCREENING TOOL

Date: _____

Name (s) : _____

Phone Number: _____

SECTION 1: SYMPTOM SCREENING

1. Do you have any of the following primary symptoms:
   - Fever New or worsening cough Shortness of breath or difficulty breathing
   - Sore throat Vomiting Diarrhea
   - Decrease or loss of smell or taste Y / N

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2. Do you have any of the following secondary symptoms:
   - Runny nose or sneezing Nasal congestion Difficulty swallowing
   - Chills Headaches Unexplainable fatigue Pink eye
   - Nausea or abdominal pain Y / N

SECTION 2: TRAVEL HISTORY / CONTACT HISTORY

3. Have you travelled outside Canada with the last 14 days? Y / N
4. Have you had close, unprotected contact with a confirmed / probable case of COVID-19? Y / N

SECTON 3: IMMEDIATELY PROCEED WITH THE FOLLOWING ACTIONS

a. If pass symptoms and travel/contact history, they can continue

b. If fail symptoms and pass travel/contact history, put on a mask and go home

c. If fail symptoms and fail travel/contact history, put on a mask, go home