Appendix 2 – Health Screening Questionnaire

Date:_____ Received by: _____

Name:_____ Phone: _____

Do you have a risk factor for COVID-19 exposure the last 14 days?

Returned from travel outside of Canada?	Yes	No
Been in close contact with anyone diagnosed with lab-confirmed COVID-19?	Yes	No
Lived or worked in a setting that is part of a COVID-19 outbreak?	Yes	No
Been advised to self-isolate or quarantine at home by public health?	Yes	No

Do you, or anyone in your household, have a <u>new</u> onset of COVID-like symptoms:

Fever	Yes	No
Cough	Yes	No
Shortness of breath	Yes	No
Diarrhea	Yes	No
Nausea and/or vomiting	Yes	No
Headache	Yes	No
Runny nose/nasal congestion	Yes	No
Sore throat or painful swallowing	Yes	No
Loss of sense of smell	Yes	No
Loss of appetite	Yes	No
Chills	Yes	No
Muscle aches	Yes	No
Fatigue	Yes	No

_____

Signature (Student/Parent/Guardian)