



Active Screening Questions: To be completed BEFORE each visit
Please circle the appropriate response

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| 1. Have you or a household member tested positive for COVID-19 in the past 10 days (on either a rapid antigen test kit or lab-based PCR test)? | YES | NO |
| 2. Has a doctor, healthcare provider, or public health unit told you that you should currently be isolating (staying at home)? | YES | NO |

3. Are you OR a household member experiencing any of the following symptoms (NOT related to other known causes or existing conditions):

- Fever and/or chills (Temperature of 37.8 degrees Celsius/100 degrees Fahrenheit or higher)
- New cough or barking cough (croup) or worsening chronic cough
- Shortness of breath
- Difficulty breathing
- Decrease or loss of sense of taste or smell
- Unexplained fatigue/malaise/muscle aches (myalgias)
- Sore throat
- Runny or stuffy/congested nose
- Headache (not related to other known causes or conditions you have)
- Nausea, vomiting, and/or diarrhea

YES

NO

If you have NOT been fully vaccinated against COVID-19*, please also answer the questions below:

**A fully immunized individual is defined as any individual >14 days after receiving their second dose of a two-dose COVID-19 vaccine series or their first dose of a one-dose COVID-19 vaccine series (ie. Johnson and Johnson)*

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| 4. In the last 14 days, have you travelled outside of Canada? | YES | NO |
| 5. In the last 10 days, have you had close contact with a confirmed case of COVID-19 without wearing PPE? | YES | NO |
| 6. In the last 10 days, have you received a COVID Alert exposure notification on your cell phone? | YES | NO |

Name (Print First, Last)

Signed

Date