Appendix A: Example COVID-19 Screening Form

*Can be adapted to separate forms for staff and clients

Date: _____

Name of Person: _____

☐ Staff ☐ Client

1. Have you travelled out of the country in the past 14 days?

☐ Yes ☐ No

2. Has someone you are in close contact with tested positive for COVID-19 in the last 14 days?

☐ Yes ☐ No

3. Are you in close contact with a person:

- who recently travelled outside of the country?
  ☐ Yes ☐ No
- who is sick with new respiratory symptoms?
  ☐ Yes ☐ No
- who has symptoms and who is awaiting COVID-19 test results?
  ☐ Yes ☐ No

4. Do you have a fever? (temperature ≥ 37.8 °C)

☐ Yes ☐ No

T° _____ (Screener will take temperature)

5. Do you have any of these symptoms?

☐ Yes ☐ No

☐ Chills ☐ Difficulty swallowing
☐ Loss of taste or smell
☐ Pink eye (conjunctivitis)
☐ New or worsening cough (dry or productive)
☐ Barking cough (croup)
☐ Shortness of breath/difficulty breathing
☐ Sore throat ☐ Unexplained fatigue/malaise
☐ Headache that is unusual or long-lasting
☐ Muscle aches ☐ Falling more than usual
☐ Runny or stuffy nose
(not related to seasonal allergies or other known causes)
☐ Nausea/vomiting/diarrhoea/abdominal pain
☐ Other_____
_____

If Person answered:

- **NO to all questions – PASS.** Person may enter the building and proceed as scheduled.
- **YES to any questions from #1 to #4 – FAIL.** Put on a surgical mask, go home immediately and self-isolate. Inform relevant health authorities.
- **YES to #5 only – FAIL. Go to question #6.**

6. Are these symptoms typical for you (i.e., history of allergies, migraines, other known medical condition that usually causes these symptoms)?

YES – Please self-isolate. For staff - contact your doctor for a note confirming that symptoms are typical before returning to work.

NO – Go home immediately and self-isolate. Inform relevant health authorities.

Screener Signature: _____ Date: _____