

COVID-19 Screening Tool

Please use your own pen/pencil to complete to prevent the spread of infection.

Name: _____

Date: _____

Time: _____

Do you have any of the following:

- | | | |
|---|-----|----|
| 1. Fever / chills | Yes | No |
| 2. New cough or a cough that is getting worse | Yes | No |
| 3. Difficulty breathing | Yes | No |
| 4. Shortness of breath (even when sitting or walking regularly) | Yes | No |
| 5. Sore throat (not due to allergies) | Yes | No |
| 6. A runny or congested nose (not due to allergies) | Yes | No |
| 7. Unusual level of fatigue | Yes | No |
| 8. Unusual headache | Yes | No |
| 9. Nausea / vomiting, diarrhea, or loss of appetite | Yes | No |
| 10. Feeling unwell for an unknown reason | Yes | No |

Has someone you are in close contact with tested positive for COVID-19?

Yes No

Have you returned from travel outside Canada in the past 14 days?

Yes No

Do you live with someone who is awaiting COVID-19 tests results who 1) was tested due to symptoms **OR** 2) was tested due to close contact with someone who tested positive?

Yes No

If you answered **YES** to any of the these questions, notify your workplace, go home and self-isolate right away. Call your health care provider or the COVID-19 Info-Line at **905-688-8248** and a public health professional will give you detailed instructions to follow to protect you, your family and members of the public.

Novel Coronavirus (COVID-19) Info-Line

Talk to a public health professional Monday to Friday from 9:15 a.m. to 8:30 p.m., and Saturday and Sunday from 9:15 a.m. to 4:15 p.m.

905-688-8248 press 7, then press 2 Toll-free: **1-888-505-6074**

niagararegion.ca/health

Niagara  Region