

COVID-19 SCREENING FORM

NAME: _____

Date: _____

Time: _____

1. Have you been diagnosed with COVID – 19?	<input type="radio"/> Yes	<input type="radio"/> No
2. If you answered yes to question 1, when were you diagnosed?	<input type="radio"/> Yes	<input type="radio"/> No
3. Have you been re-tested and deemed recovered?	<input type="radio"/> Yes	<input type="radio"/> No
4. Do you have a sore throat?	<input type="radio"/> Yes	<input type="radio"/> No
5. Do you have difficulty swallowing?	<input type="radio"/> Yes	<input type="radio"/> No
6. Do you have shortness of breath?	<input type="radio"/> Yes	<input type="radio"/> No
7. Do you have difficulty breathing?	<input type="radio"/> Yes	<input type="radio"/> No
8. Do you have a newly onset cough?	<input type="radio"/> Yes	<input type="radio"/> No
9. Do you have a worsening persistent cough?	<input type="radio"/> Yes	<input type="radio"/> No
10. Do you have headache?	<input type="radio"/> Yes	<input type="radio"/> No
11. Do you have chills?	<input type="radio"/> Yes	<input type="radio"/> No
12. Do you have a fever?	<input type="radio"/> Yes	<input type="radio"/> No
13. Do you have a decrease or loss of taste or smell?	<input type="radio"/> Yes	<input type="radio"/> No
14. Do you have unexplained fatigue, malaise or muscle soreness?	<input type="radio"/> Yes	<input type="radio"/> No
15. Do you have nausea, vomiting, diarrhea, or abdominal pain?	<input type="radio"/> Yes	<input type="radio"/> No
16. Do you have pink eye?	<input type="radio"/> Yes	<input type="radio"/> No
17. Do you have runny nose or nasal congestion without a known cause like allergies?	<input type="radio"/> Yes	<input type="radio"/> No
18. Do you have a hoarse voice (children under 18)?	<input type="radio"/> Yes	<input type="radio"/> No
19. Do you have a new onset skin rash (children under 18)?	<input type="radio"/> Yes	<input type="radio"/> No
20. Do you have skin changes on toes (children under 18)?	<input type="radio"/> Yes	<input type="radio"/> No
21. Are you experiencing new symptoms of dizziness?	<input type="radio"/> Yes	<input type="radio"/> No
22. Have you been in contact with someone who has been diagnosed with COVID – 19?	<input type="radio"/> Yes	<input type="radio"/> No
23. Have you been in contact with someone who was diagnosed with COVID – 19 and has been deemed (medically) as recovered?	<input type="radio"/> Yes	<input type="radio"/> No
24. Have you been in close contact with someone who has shown symptoms of COVID-19?	<input type="radio"/> Yes	<input type="radio"/> No
25. Have you been in contact someone who has acute respiratory illness?	<input type="radio"/> Yes	<input type="radio"/> No
26. Have you travelled outside of Ontario within the last 14 days?	<input type="radio"/> Yes	<input type="radio"/> No
27. Do you work in a setting where an outbreak has occurred (adults accompanying a child to ISAND)	<input type="radio"/> Yes	<input type="radio"/> No