

Staff/ Professional Staff Screening Card

1. Are you experiencing any of the following symptoms? (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Fever of 37.8 degree C. | <input type="checkbox"/> New or Worsening Cough |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Runny nose or nasal congestion |
| <input type="checkbox"/> Change or loss of sense of taste and/or smell | <input type="checkbox"/> Sore Throat and/or pain swallowing |
| <input type="checkbox"/> Nausea/ vomiting, diarrhea, abdominal pain | <input type="checkbox"/> No symptoms |

YES NO

2. Have you had close contact, including living in the same household, with a confirmed COVID-19 positive individual in last 14 days?

(sharing food, living in the same household, without PPE)

3. Have you travelled outside of Canada within the last 14 days?

Please submit the completed screening card to the screener upon entry.

If you are experiencing any of the symptoms listed above, please immediately notify your leader, Employee Health Safety & Wellness.

DATE:

**Staff Name
(Print Name)**

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