

## 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"/> Loss of sense of taste or smell            | <input type="checkbox"/> Sore Throat and/or difficulty swallowing |
| <input type="checkbox"/> Nausea/ vomiting, diarrhea, abdominal pain | <input type="checkbox"/> No symptoms                              |

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)*

YES      NO

<input type="checkbox"/>	<input type="checkbox"/>
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3. Have you travelled outside of Canada within the last 14 days?

<input type="checkbox"/>	<input type="checkbox"/>
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**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**

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