COVID-19 Daily Screening Questionnaire for Staff and Visitors

STAFF / VISITORS MUST COMPLETE THIS QUESTIONNAIRE DAILY

1.	Do you have any of the below symptoms:	CIRCLE ONE	
	• Fever	YES	NO
	• Cough	YES	NO
	• Shortness of Breath / Difficulty Breathing	YES	NO
	• Sore Throat	YES	NO
	• Chills	YES	NO
	• Painful Swallowing	YES	NO
	• Runny Nose /Nasal Congestion	YES	NO
	• Feeling Unwell / Fatigued	YES	NO
	• Nausea / Vomiting /Diarrhea	YES	NO
	• Unexplained Loss of Appetite	YES	NO
	• Loss of Sense of Taste or Smell	YES	NO
	• Muscle or Joint Aches	YES	NO
	• Headache	YES	NO
	• Conjunctivitis (Pink Eye)	YES	NO
2.	**Do you have a temperature over 38.0 degrees C (100.4 degrees F) this morning?**	YES	NO
3.	**Have you travelled outside of Canada in the last 14 days?**	YES	NO
4.	**Have you or anyone in your household had close contact* with someone who has travelled outside of Canada in the last 14 days?**	YES	NO
5.	**Have you or anyone in your household had close contact* in the last 14 days with someone who is "ill"****	YES	NO
6.	**Have you or anyone in your household been in close contact* in the last 14 days with someone who is either confirmed or currently being investigated to be a case of COVID-19?**	YES	NO

* "close contact" means within 2 meters / 6 feet)

** "ill" means someone with COVID symptoms on the list above

If you have answered "**Yes**" to any of the above questions, please **DO NOT** enter the school at this time. You should stay home and use the COVID-19 Self-Assessment Tool to determine whether you need to be tested for COVID-19.

If you have answered "**No**" to all of the above questions, you may enter the school or school bus provided you have completed this form.

TEMPERATURE TAKEN THIS MORNING

I verify the information I have provided on this form is truthful and accurate.

_____ _____ _____

Signature Printed Name Today's Date (Day/Month/Year)