COVID-19 Screening

1. Do you have a fever?

- Yes
- No

2. Do you have any of the following signs or symptoms?

- New onset of cough
- Runny nose
- Unusual or long lasting headache
- Worsening chronic cough
- Sneezing (not allergy-related)
- Unexplained fatigue or malaise
- Sore throat
- Hoarse voice
- Difficulty swallowing
- Shortness of breath
- Nasal congestion
- Nausea/vomiting, diarrhea, abdominal pain
- Difficulty breathing
- Chills
- Pink eye (conjunctivitis)
- New loss or decrease in sense of taste or smell

3. Have you travelled or have had close contact with anyone who has travelled outside of Canada in the past 14 days?

- Yes
- No

4. Have you had close contact with anyone with respiratory illness or a confirmed or probable/suspected case of COVID-19?

- Yes (if yes, go to question 5)
- No (if no, screening is complete)

5. Did you wear the required and/or recommended PPE according to the type of duties you were performing (e.g., goggles, gloves, mask and gown or N95 with aerosol generating medical procedures when you had close contact with a suspected or confirmed case of COVID-19?

- Yes
- No

Consent*

I acknowledge and accept that there is a risk that I could be exposed to COVID-19 while attending at the Facility. I also acknowledge and accept that while receiving services, the Health Care Provider (HCP) may need to be closer than the recommended social distancing guidelines in order to assess and/or treat me. I acknowledge and confirm that I am willing to accept this risk as a condition of attending at the Facility to receive services from the HCP.

In consideration of the HCP agreeing to see me in person at the Facility, I agree to release the HCP and the Facility (if applicable), their officers, directors, employees, agents and volunteers (the "Releasees") from any and all causes of action, claims, demands, requests, damages or any recourse whatsoever in respect of any personal injuries or other damages which may occur or arise as a result of exposure to COVID-19 during my visit to the Facility and/or through the provision of services to me by the HCP.

Date:

Name:

Signature: