

Screening Questions: COVID-19 Vaccination Clinic

INSTRUCTIONS:

- Please **complete this form on the day of your appointment, print it and bring it to your appointment.**

If you answered Yes to questions 1-4, please reschedule your appointment for a day when you are symptom-free and can answer No to questions 1-4.		
1. Do you have any of the following symptoms?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Fever (temperature of ≥ 37.8 C) <input type="checkbox"/> Cough <input type="checkbox"/> Sore throat <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chills <input type="checkbox"/> Changes in your sense of taste/smell <input type="checkbox"/> Runny nose, sneezing, nasal congestion (not due to other underlying reasons like seasonal allergies or post-nasal drip) <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> New headache <input type="checkbox"/> Unexplained fatigue/malaise <input type="checkbox"/> Nausea, vomiting, diarrhea, abdominal pain		
2. Have you been tested for COVID-19 due to symptoms and are awaiting results? (Asymptomatic/Surveillance testing does not apply and is not a reason for exclusion.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Have you tested positive for COVID-19 in the last 10 days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. In the last 14 days, have you travelled outside Canada?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. In the past 14 days, have you had close*, unprotected contact with any of the following:		
<input type="radio"/> a sick traveller	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="radio"/> a suspected or confirmed case of COVID-19?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

*Close, unprotected contact is defined as having provided care, had similar close physical contact, or had lived with or otherwise had close, prolonged contact without appropriate PPE.

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