CLIENT SCREENING

Complete this self-assessment before entering the workplace

First Name:

Last Name:

Date:_____ I am NOT EXPERIENCING

And not related to known causes or existing conditions

- Fever and/or chills, Cough or barking cough.
- Shortness of breath, Decrease or loss of smell or taste.
- Nausea, Vomiting and/or diarrhea, Sore throat, Runny or congested nose.

Symptoms below don't apply if you began to experience them only after being vaccinated to COVID-19 in the last 48 hours.

- Muscle aches/joint pain, Extreme tiredness, Headache.

During the last 14 days, I have not

- Been travelling outside of Canada AND been advised to quarantine per federal requirement.

In the last 10 days, I have not

- Been tested positive on a rapid antigen test or home-based self-testing kit.
- Been living with someone with symptoms associated with COVID-19 and/or tested positive for COVID-19.
- Received a COVID Alert exposure notification on my cell phone.
- Been identified as a "close contact" of someone who has COVID-19 (confirmed by a PCR test or antigen test). Does not apply if you have since been cleared by public health.

If upon completion of the screening tool “I decline” is selected, contact a Manager or Director during office hours (345-9933) or an On-Call Supervisor after hours (626-4825) to share information and receive further direction.

Please circle one:

I confirm

I decline

Signature: _____ Name of Staff: _____