COVID-19 Screening Questions

Name: _____ **Date:** _____

Temperature: _____ **Signatures:** _____

Symptom and exposure screening questions (check all that apply)

A. Do you have a new onset, or worsening, of any ONE of the following symptoms?	**Yes**	**No**
• Fever > 38°C or subjective fever/ chills		
• Cough		
• Sore throat/ hoarse voice		
• Shortness of breath/ breathing difficulties		
• Loss of taste or smell		
• Vomiting or diarrhea for more than 24 hours		
If "yes" to any one of the above, DO NOT ENTER		
B. Do you have a new onset, or worsening, of any TWO of the following symptoms?	**Yes**	**No**
• Runny nose		
• Fatigue / Muscle aches		
• Conjunctivitis (pink eye)		
• Headache		
• Skin rash of unknown cause		
If "yes" to any one of the above, DO NOT ENTER		
Exposure history	**Yes**	**No**
1. Have you, or a member of your household, been in close contact (within 2 metres / 6 feet for more than 10 minutes total over 24 hours) in the last 14 days with a confirmed COVID-19 case?		
2. Have you been exposed to COVID-19 in a work or public setting		
3. Have you, or a member of your household, travelled outside of Country in the past 14 days?		
4. Is a member of your household sick with COVID-19 symptoms, and waiting for COVID-19 test results?		
If "yes" to any one of the above, DO NOT ENTER		

*If the checklist advises you Not to Enter: stay home, isolate and call your doctor or local public health authority.

Please email the form to: info@justdentalcare.com For any question or inquiry please call at 613-200-3200