**Findings Resource Centre Inc**
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FRC Findings Resource Centre Inc.

# COVID-19 Screening Questionnaire

Date ________________ Name ________________________________

Signature: ________________________________________________

| ☐ Staff member | ☐ Program Participant | ☐ Visitor |
|---|---|---|

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|---|---|---|---|
| 1. | Do you have any of the following symptoms: | | |
| | Fever (Greater than $37.5^{o}$ C) | Yes | No |
| | Cough | Yes | No |
| | Sore throat | Yes | No |
| | Runny nose | Yes | No |
| | Shortness of breath / Difficulty Breathing | Yes | No |
| | Feeling unwell / Fatigued | Yes | No |
| | Nausea / Vomiting / Diarrhea | Yes | No |
| 2. | Have you, or anyone in your household, traveled outside of Canada for the last 14 days? | Yes | No |
| 3. | Have you had close contact with someone who is ill with cough and/or fever? (face-to-face contact within 2 meters / 6 feet) | Yes | No |
| 4. | Have you or anyone in your household (or extended family) been in contact in the last 14 days with someone who is being investigated or confirmed to be a case of COVID 19, either socially or at work. EG: At work, community tracing | Yes | No |


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