

**COVID-19 SCREENING FOR CUSTOMERS**

These questions are based on the screening tool developed by Ontario Ministry of Health.

**To protect the health of customers and workers, please answer the following questions.**

Unless you agree, you will not be traced in the event of exposure to COVID-19 infected person.

Are you 18 years of age or older? p Yes p No

Are you currently experiencing any of these symptoms?

Choose any/all that are new, worsening, and not related to other known causes or conditions you already have.

p Fever and/or chills

Temperature of 37.8 degrees Celsius/100 degrees Fahrenheit or higher

p Cough or barking cough (croup)

Continuous, more than usual, making a whistling noise when breathing (not related to asthma, post-infectious reactive airways, COPD, or other known causes or conditions you already have)

p Shortness of breath

Out of breath, unable to breathe deeply (not related to asthma or other known causes or conditions you already have)

p Sore throat

Not related to seasonal allergies, acid reflux, or other known causes or conditions you already have

p Difficulty swallowing

Painful swallowing (not related to other known causes or conditions you already have)

p Runny or stuffy/congested nose

Not related to seasonal allergies, being outside in cold weather, or other known causes or conditions you already have

p Decrease or loss of taste or smell

Not related to seasonal allergies, neurological disorders, or other known causes or conditions you already have

p Pink eye

Conjunctivitis (not related to reoccurring styes or other known causes or conditions you already have)

p Headache

Unusual, long-lasting (not related to tension-type headaches, chronic migraines, or other known causes or conditions you already have)

p Digestive issues like nausea/vomiting, diarrhea, stomach pain

Not related to irritable bowel syndrome, menstrual cramps, or other known causes or conditions you already have

p Muscle aches

Unusual, long-lasting (not related to a sudden injury, fibromyalgia, or other known causes or conditions you already have)

p Extreme tiredness

Unusual, fatigue, lack of energy (not related to depression, insomnia, thyroid dysfunction, or other known causes or conditions you already have)

p Falling down often

For older people

p None of the above

## In the last 14 days, have you travelled outside of Canada? If you are an essential worker who crosses the Canada-US border regularly for work, select “No.”

p Yes p No

## In the last 14 days, have you been identified as a “close contact” of someone who currently has COVID-19?

p Yes p No

## In the last 14 days, have you received a COVID Alert exposure notification on your cell phone? If you already went for a test and got a negative result, select “No.”

p Yes p No

This result is no longer valid if your situation changes during the day (for example, you start experiencing symptoms).

The people with you should also take this screening. You can take it on their behalf if they cannot do it themselves.

**OPTIONAL** – for tracing, the event you are exposed to COVID-19 infected person

**NOTE: We will NOT use this information for marketing purposes without your consent.**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_

Contact Information: Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I consent to being added to your mailing list. p Yes p No