FSESO REQUIRED COVID-19 SCREENING QUESTIONS

Name:_____(Please Print) Contact Number _____

1. Are you currently experiencing any one of the symptoms below that are new or worsening? Symptoms should not be chronic or related to other known causes or conditions.

Do you have any one of the following symptoms? Yes ☐ No ☐

Fever and/or chills	Temperature of 37.8 C/100 F degrees or higher
Cough or barking cough (croup)	Not related to asthmas, post-infectious reactive airways, COPD, or other known causes or conditions you already have
Shortness of breath	Not related to asthma or other known causes or conditions you already have
Sore throat	Not related to seasonal allergies, acid reflux, or other known causes or conditions you already have
Difficulty swallowing	Painful swallowing not related to other known causes or conditions you already have
Decrease or loss of smell or taste	Not related to seasonal allergies, acid reflux, or other known causes or conditions you already have
Pink eye	Conjunctivitis not related to reoccurring styes or other know causes or conditions you already have
Runny or stuff/congested nose	Not related to seasonal allergies, acid reflux, or other known causes or conditions you already have
Headache	Unusual, long-lasting not related to tension-type headaches, chronic migraines, or other known causes or conditions you already have
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
Muscle aches	Unusual, long-lasting (not related to a sudden injury, fibromyalgia, or other known causes or conditions you already have)
Extreme tiredness	Unusual, fatigue, lack of energy (not related to depression, insomnia, thyroid dysfunction, or other known causes or conditions you already have
Falling down often	For older people

2. Is anyone you live with currently experiencing any new COVID-19 symptoms and/or waiting for test results after experiencing symptoms?

- If you are fully vaccinated (it has been 14 or more days since your final dose of either a two-dose or a one-dose vaccine series), select “No.”
- If the person got a CVOID-19 vaccine in the last 48 hours and is experiencing a mild headache, fatigue, muscle aches, and/or joint pain that only began after vaccination, select “No.”

Yes ☐ No ☐

3. In the last 14 days, have you travelled outside of Canada?
If exempt from federal quarantine requirements (for example, you are fully vaccinated and have met the specific conditions, or an essential worker who crosses the Canada-US border regularly for work), select “No.”

Yes ☐ No ☐

4. In the last 14 days, have you been identified as a “close contact” of someone who currently has COVID-19?
If you are fully vaccinated (it has been 14 or more days since your final dose of either a two-dose vaccine series) and have not been told to self-isolate by public health, select “No.”

Yes ☐ No ☐

5. Has a doctor, health care provider, or public health unit told you that you should currently be isolating (staying at home)?
This can be because of an outbreak or contact tracing.

Yes ☐ No ☐

6. In the last 10 days, have you tested positive on a rapid antigen test or home-based self-testing kit?
If you have since tested negative on a lab-based PCR test, select “No.”

Yes ☐ No ☐

7. In the last 14days, have you received a COVID Alert exposure notification on your cell phone?
If you are fully vaccinated (it has been 14 or more days since your final dose of either a two-dose or a one-dose vaccine series), select “No.” If you already went for a test and got a negative result, select “No.”

Yes ☐ No ☐

Anyone making false or misleading statements with respect to the above questions will be removed from the course immediately without refund. Please see your instructor if you have any questions.

Signature **Date**