

EASTER SEALS ONTARIO COVID-19 EVENT SCREENING

1. Do you have any of the following new or worsening symptoms or signs?

Yes No



Fever or chills

Yes No



Cough

Yes No



Trouble breathing

Yes No



Decrease or loss of taste or smell

Yes No



Nausea, vomiting or diarrhea
 (age <18 only)

Yes No



Very tired, sore muscles or joints*
 (age 18+ only)

If you have an existing health condition that gives you the symptoms, select "No," unless the symptom is new, different or getting worse.

*If mild tiredness, sore muscles or joints occur within 48 hours after getting a COVID-19 vaccine, select "No" and continue to follow all public health measures. If symptoms last longer than 48 hours or worsen, select "Yes".

If "YES" to any symptoms:



Stay home & self-isolate



Get tested

Or



Contact a health care provider

2. Does anyone in your household have one or more of the above symptoms and/or are waiting for test results after experiencing symptoms? Yes No

3. In the last 10 days have you been notified as a close contact of someone with COVID-19 or been told to stay home and self isolate? Yes No

4. In the last 10 days, have you tested positive on a rapid antigen test or a home-based self-testing kit? Yes No

5. In the last 14 days, have you travelled outside of Canada AND been advised to quarantine per the federal quarantine requirements? Yes No

If "YES" to questions 2, 3, 4 or 5:



Do not enter this location



Follow Public Health advice

I confirm that I have answered this screening tool honestly and to the best of my ability.

First and Last Name (Please Print)

Phone Number

Date (mm/dd/yyyy)