Klinic COMMUNITY HEALTH

Name: _____

Appointment with: _____

Cell Phone #: _____

Date: _____

1. Do you have any of the following symptoms: **Please circle all that apply below**

1 or more from Category A or 2 or more from Category B = Positive screen

Category A	Category B
Fever over 38 degrees or subjective fever/chills	**Runny Nose**
Cough	**Muscle Aches**
Sore Throat / Hoarse Voice	**Fatigue**
Shortness of Breath/Breathing Difficulties	**Pink eye (eye infection)**
Loss of Smell or Taste	**Headache**
Vomiting or Diarrhea for more than 24 hours	**Skin rash of an unknown cause**
	Poor feeding (if an infant)
	Nausea or Loss of Appetite

2. Have you tested positive for COVID-19 in the last 10 days (either by rapid test or laboratory-based test)? **YES or NO**

3. Have you been exposed in the last 14 days to someone that has tested positive for COVID-19 (either by rapid test or laboratory-based test) or has COVID-19 symptoms? **YES or NO**

4. Have you travelled internationally (outside of Canada) in the last 14 days WHILE not fully vaccinated? **YES or NO**

If yes to any part of questions 1 through 4 please inform the Floor Medical Assistant or Front Desk to move client into an isolation room.

If no to questions 1 through 4 allow client to check in and be seated in waiting area.