

Appendix A: Visitor and Volunteer Screening Questionnaire

Visitor and Volunteer Screening Questionnaire

FILL OUT THIS QUESTIONNAIRE TO DECIDE IF YOU SHOULD ENTER TODAY

Risk Assessment: Initial Screening Questions:

| 1. | Do you have any of the below symptoms: | CIRCLE ONE | |
|----|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-----------|
| | <ul style="list-style-type: none"> • Fever (greater than 38 degrees) | YES | NO |
| | <ul style="list-style-type: none"> • Cough | YES | NO |
| | <ul style="list-style-type: none"> • Shortness of breath/breathing difficulties | YES | NO |
| | <ul style="list-style-type: none"> • Other symptoms such as muscle aches, fatigue, headache, sore throat, runny nose, diarrhea. Note symptoms in young children may be non-specific – e.g. lethargy, poor feeding | YES | NO |
| 2. | Have you travelled outside of Canada in the last 14 days? | YES | NO |
| 3. | Have you had close contact (face-to-face contact within 2 meters/6 feet) with someone who is ill with cough and/or fever? | YES | NO |
| 4. | Have you been in contact in the last 14 days with someone that is being investigated or confirmed to be a case of COVID-19? | YES | NO |
| 5. | Have you had laboratory exposure while working with specimens known to contain COVID-19? | YES | NO |

If you have answered “**Yes**” to any of the above questions, please **DO NOT** enter at this time.

If you have answered “**No**” to all the above questions, please sign in and out and practice hand hygiene (wash hands for 30 seconds, and or use hand sanitizer) before and after your visit.

Our goal is to minimize the risk of infection to our residents and staff, thank you for your understanding and cooperation.

Name (Printed): _____ **Signature:** _____

Date: _____