



VIETNAMESE COMMUNITY CENTER OF MISSISSAUGA
TRUNG TÂM CỘNG ĐỒNG VIỆT NAM MISSISSAUGA

600 Lakeshore Road East, Mississauga, ON L5G 1J4 Tel: (905) 891-3825

COVID – 19 Client Screening Questionnaire

All clients must complete before entering the community center.

* required

First Name *:

Last Name *:

Email:

Phone Number *:

Date & Time *: :

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

	Yes	No
Fever or chills	<input type="checkbox"/>	<input type="checkbox"/>
Runny or stuffy nose	<input type="checkbox"/>	<input type="checkbox"/>
*Headache	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat or trouble swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Pink eye	<input type="checkbox"/>	<input type="checkbox"/>
Trouble breathing	<input type="checkbox"/>	<input type="checkbox"/>
Nausea, vomiting or diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Decrease or loss of taste or smell	<input type="checkbox"/>	<input type="checkbox"/>
*Very tired, sore muscles or joints	<input type="checkbox"/>	<input type="checkbox"/>

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 headache, tiredness, sore muscles or joints occur within 48 hours after getting a COVID-19 vaccine, select **"No"** and wear a medical mask when at work. 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. Have you gotten your COVID-19 vaccine? *

- I have received my **first dose**
- I have received my **second dose**
- I have **not** received my COVID-19 vaccine
- I prefer not to answer

3. Does anyone in your household have one or more symptoms and/or are waiting for test results after experiencing symptoms? *

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No

4. Have you been notified as a close contact of someone with COVID-19 or been told to stay home and self-isolate? *

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No

5. In the last 10 days, have you tested positive on a rapid antigen test or home-based self-testing kit? *

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No

6. In the last 14 days, have you travelled outside of Canada AND been advised to quarantine per the federal quarantine requirements? *

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No

If “YES” to questions 2, 3, 4 or 5: Stay home + follow Toronto Public Health advice

For instructions on self-isolation and what to do if you have symptoms, visit www.EOHU.ca/coronavirus.