Dundas Family Dental

COVID-19 Screening Questionnaire (Please circle your response)			
Q1.	Have you received the final (second) dose of COVID-19 vaccine more than 14 days ago?	Yes	No
Q2.	Have you had close contact with a person with a confirmed case of COVID-19 without wearing appropriate PPE?	Yes	No
Q3.	Do you have any of the following symptoms: • Fever and/or chills • New onset of cough • New onset or worsening chronic cough • Shortness of breath • Decreased or loss of sense, taste or smell Adults 18 years and over: • Unexplained fatigue/lethargy/malaise or muscle ache (myalgia) Under 18 years old: • Nausea/vomiting/diarrhea	Yes	No
Q4.	Have you tested POSITIVE for COVID-19 in the past 10 days or have you been told to self-isolate?	Yes	No
Please answer Q5 and Q6 only if you are NOT fully vaccinated (answered NO to Q1)			
Q5.	Have you travelled outside of Canada in the past 14 days?	Yes	No
Q6.	Have you had close contact with a person with a confirmed case of COVID-19 without wearing appropriate PPE?	Yes	No

Signature: _____ Date: _____

Name (Print): _____ Temperature©: _____

Revised September 3, 2021