

# ARENA HEALTH SCREENING

## ADULTS 18 and Over

1. Do you have one or more of the following symptoms?

**Fever and/or Chills**

Temperature of 37.8 degrees Celsius/100 degrees Fahrenheit or higher.

**Cough or Barking Cough (Croup)**

Not related to asthma, post-infectious reactive airways, COPD, or other known causes or conditions you already have.

**Shortness of Breath**

Not related to asthma or other known causes or conditions you already have.

**Sore Throat**

Not related to seasonal allergies, acid reflux, or other known causes or conditions you already have.

**Difficulty Swallowing**

Painful swallowing (not related to other known causes or conditions you already have).

**Decrease or loss of smell or taste**

Not related to seasonal allergies, neurological disorders, or other known causes or conditions you already have.

**Pink Eye**

Conjunctivitis (not related to reoccurring styes or other known causes or conditions you already have).

**Runny or stuffy/congested nose**

Not related to seasonal allergies, being outside in cold weather, or other known causes or conditions you already have.

**Headache**

Unusual, long-lasting (not related to tension-type headaches, chronic migraines, or other known causes or conditions you already have)

If you received a COVID-19 vaccination in the last 48 hours and are experiencing a mild headache that only began after vaccination, select "No."

**Digestive issues like nausea/vomiting, diarrhea, stomach pain**

Not related to irritable bowel syndrome, menstrual cramps, or other known causes or conditions you already have.

**Muscle aches/joint pain**

Unusual, long-lasting (not related to a sudden injury, fibromyalgia, or other known causes or conditions you already have)

If you received a COVID-19 vaccination in the last 48 hours and are experiencing mild muscle aches/joint pain that only began after vaccination, select "No."

**Fatigue**

Unusual tiredness, lack of energy (not related to depression, insomnia, thyroid dysfunction, or other known causes or conditions you already have)

If you received a COVID-19 vaccination in the last 48 hours and are experiencing mild fatigue that only began after vaccination, select "No."



**If you answered no to all symptoms please proceed to the next question.**

2. Has a doctor, health care provider, or public health unit told you that you should currently be isolating?



**If you answered no, please proceed to the next question.**

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



**If you answered no, please proceed to the next question.**

4. In the last 14 days, have you been identified as a "close contact" of someone who currently has COVID-19?



**If you answered no, please proceed to the next question.**

5. In the last 14 days, have you received a COVID Alert exposure notification on your cell phone?



**If you answered no, please proceed to the next question.**

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



**If you answered no, please proceed to the next question.**

7. In the last 14 days, has someone in your household (someone you live with):

• travelled outside of Canada AND been advised to quarantine per the federal quarantine requirements; OR

• been identified as a "close contact" of someone who currently has COVID-19 AND advised by a doctor, healthcare provider or public health unit to self-isolate?



**If you answered no, please proceed to the next question.**

8. Is anyone you live with currently experiencing any new COVID-19 symptoms and/or waiting for test results after experiencing symptoms?



**If you answered YES to any of the above questions please leave the facility immediately and contact Public Health.**



**If you answered NO to all of the above questions please SCREEN IN and enter the facility.**

# ARENA HEALTH SCREENING

## Youth Under 18

1. Do you have one or more of the following symptoms?

**Fever and/or Chills**

Temperature of 37.8 degrees Celsius/100 degrees Fahrenheit or higher.

**Cough or Barking Cough (Croup)**

Continuous, more than usual, making a whistling noise when breathing (not related to asthma, post-infectious reactive airways, or other known causes or conditions you already have)

**Shortness of Breath**

Out of breath, unable to breathe deeply (not related to asthma or other known causes or conditions you already have)

**Sore Throat**

Not related to seasonal allergies, neurological disorders, or other known causes or conditions you already have.

**Difficulty Swallowing**

Painful swallowing (not related to other known causes or conditions you already have).

**Decrease or loss of smell or taste**

Not related to seasonal allergies, neurological disorders, or other known causes or conditions you already have.

**Runny or stuffy/congested nose**

Not related to seasonal allergies, being outside in cold weather, or other known causes or conditions you already have.

**Headache**

Unusual, long-lasting (not related to tension-type headaches, chronic migraines, or other known causes or conditions you already have)

If you received a COVID-19 vaccination in the last 48 hours and are experiencing a mild headache that only began after vaccination, select "No."

**Nausea/vomiting, diarrhea, stomach pain**

Not related to irritable bowel syndrome, anxiety, menstrual cramps, or other known causes or conditions you already have.

**Extreme tiredness or muscle aches**

Unusual, fatigue, lack of energy (not related to depression, insomnia, thyroid dysfunction, sudden injury, or other known causes or conditions you already have)

If you received a COVID-19 vaccination in the last 48 hours and are experiencing mild muscle aches that only began after vaccination, select "No."

If you received a COVID-19 vaccination in the last 48 hours and are experiencing mild fatigue that only began after vaccination, select "No."



**If you answered no to all symptoms please proceed to the next question.**

2. Has a doctor, health care provider, or public health unit told you that you should currently be isolating?



**If you answered no, please proceed to the next question.**

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



**If you answered no, please proceed to the next question.**

4. In the last 14 days, have you been identified as a "close contact" of someone who currently has COVID-19?



**If you answered no, please proceed to the next question.**

5. In the last 14 days, have you received a COVID Alert exposure notification on your cell phone?



**If you answered no, please proceed to the next question.**

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



**If you answered no, please proceed to the next question.**

7. In the last 14 days, has someone in your household (someone you live with):

• travelled outside of Canada AND been advised to quarantine per the federal quarantine requirements; OR

• been identified as a "close contact" of someone who currently has COVID-19 AND advised by a doctor, healthcare provider or public health unit to self-isolate?



**If you answered no, please proceed to the next question.**

8. Is anyone you live with currently experiencing any new COVID-19 symptoms and/or waiting for test results after experiencing symptoms?



**If you answered YES to any of the above questions please leave the facility immediately and contact Public Health.**



**If you answered NO to all of the above questions please SCREEN IN and enter the facility.**