

Office of the Chief Medical Officer of Health

# COVID-19 Screening Tool for Businesses and Organizations (Screening Workers)

Version 2 – January 7, 2021

This screening tool provides advice, recommendations and instructions issued by the Office of the Chief Medical Officer of Health in accordance with subsections 2(3) of Schedule 1 to [O. Reg. 82/20: Rules for Areas in Stage 1](#) under the [Reopening Ontario \(A Flexible Response to COVID-19\) Act, 2020](#).

The person responsible for a business or organization that is permitted to be open under *O. Reg. 82/20: Rules for Areas in Stage 1* must screen workers for COVID-19 before they go to work or start their shift each day.

This screening tool is not to be used as a clinical assessment tool or intended to take the place of medical advice, diagnosis, treatment or legal advice.

The questions in this tool have been defined by the Ministry of Health. These questions can be adapted to meet the communication the needs of people with learning, developmental or cognitive disabilities.

This screening tool does not apply to health care settings (including [long-term care homes](#)), and some non-health care workplaces (e.g., [retirement homes](#), other congregate living settings, schools and [schools and child care](#)) where existing screening requirements and tools are already in place.

Screening is not required for emergency services or other first responders entering a workplace for emergency purposes.

Screening should occur before or when the worker arrives at the workplace at the business or organization at the beginning of their shift or workday. This means ensuring that the result of screening is collected and reviewed to determine whether a person may enter the workplace.

This screening tool can be completed either online or on-site before the worker enters the workplace. Anyone who does not pass screening should be advised they should not enter the workplace and should self-isolate, ideally at home, and call their health care provider or Telehealth Ontario ([1-866-797-0000](#)) for clinical assessment.

## Required Screening Questions

**For individuals who are 18 years of age and older.**

1. Do you have any of the following new or worsening symptoms or signs? Symptoms should not be chronic or related to other known causes or conditions.

Choose any/all that are new, worsening, and not related to other known causes or medical conditions.

<p><b>Fever and/or chills</b></p> <p>Temperature of 37.8 degrees Celsius/100 degrees Fahrenheit or higher</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p><b>Cough or barking cough (croup)</b></p> <p>Continuous, more than usual, making a whistling noise when breathing, not related to other known causes or conditions (for example, asthma, post-infectious reactive airways, COPD)</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p><b>Shortness of breath</b></p> <p>Out of breath, unable to breathe deeply, not related to other known causes or conditions (for example, asthma)</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p><b>Decrease or loss of smell or taste</b></p> <p>Not related to other known causes or conditions (for example, allergies, neurological disorders)</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p><b>Sore throat</b></p> <p>Not related to other known causes or conditions (for example, seasonal allergies, acid reflux)</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p><b>Difficulty swallowing</b></p> <p>Painful swallowing, not related to other known causes or conditions</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<b>Pink eye</b> Conjunctivitis, not related to other known causes or conditions (for example, reoccurring styes)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Runny or stuffy/congested nose</b> Not related to other known causes or conditions (for example, seasonal allergies, being outside in cold weather)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Headache that's unusual or long lasting</b> Not related to other known causes or conditions (for example, tension-type headaches, chronic migraines)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Digestive issues like nausea/vomiting, diarrhea, stomach pain</b> Not related to other known causes or conditions (for example, irritable bowel syndrome, menstrual cramps)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Muscle aches that are unusual or long lasting</b> Not related to other known causes or conditions (for example, a sudden injury, fibromyalgia)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Extreme tiredness that is unusual</b> Fatigue, lack of energy, not related to other known causes or conditions (for example, depression, insomnia, thyroid dysfunction)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Falling down often</b> For older people	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**For individuals who are less than 18 years of age.**

1. Do you have any of the following new or worsening symptoms or signs? Symptoms should not be chronic or related to other known causes or conditions.

<p><b>Fever and/or chills</b></p> <p>Temperature of 37.8 degrees Celsius/100 degrees Fahrenheit or higher</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p><b>Cough or barking cough (croup)</b></p> <p>Continuous, more than usual, making a whistling noise when breathing, not related to other known causes or conditions (for example, asthma, post-infectious reactive airways)</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p><b>Shortness of breath</b></p> <p>Out of breath, unable to breathe deeply, not related to other known causes or conditions (for example, asthma)</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p><b>Decrease or loss of smell or taste</b></p> <p>Not related to other known causes or conditions (for example, allergies, neurological disorders)</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p><b>Sore throat or difficulty swallowing</b></p> <p>Painful swallowing, not related to other known causes or conditions (for example, seasonal allergies, acid reflux)</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p><b>Runny or stuffy/congested nose</b></p> <p>Not related to other known causes or conditions (for example, seasonal allergies, being outside in cold weather)</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<p><b>Headache that's unusual or long lasting</b></p> <p>Not related to other known causes or conditions (for example, tension-type headaches, chronic migraines)</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p><b>Nausea, vomiting and/or diarrhea</b></p> <p>Not related to other known causes or conditions (for example, irritable bowel syndrome, anxiety in children, menstrual cramps)</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p><b>Extreme tiredness that is unusual or muscle aches</b></p> <p>Fatigue, lack of energy, poor feeding in infants, not related to other known causes or conditions (for example, depression, insomnia, thyroid dysfunction, sudden injury)</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

2. Have you travelled outside of Canada in the last 14 days?

If you are an essential worker who crosses the Canada-US border regularly for work, select "No".

Yes

No

3. In the last 14 days, has a public health unit identified you as a close contact of someone who currently has COVID-19?

Yes

No

4. Has a doctor, health care provider, or public health unit told you that you should currently be isolating (staying at home)?

Yes

No

5. In the last 14 days, have you received a COVID Alert exposure notification on your cell? If you already went for a test and got a negative result, select "No."

Yes

No

## Results of Screening Questions:

- If the worker answered **NO to all questions from 1 through 5**, they can enter the workplace.
- If the worker answered **YES to any questions from 1 through 5\***, they should not enter the workplace (including any outdoor, or partially outdoor workplace). They should inform their employer of this result and go or stay home to self-isolate immediately and contact their health care provider or Telehealth Ontario (1 866-797-0000) to find out if they need a COVID-19 test.

\*Essential workers who travel outside of Canada for work purposes (see [Group Exemptions, Quarantine Requirements](#) under the *Quarantine Act*) should not fail their screen on the basis of their work-related travel alone (i.e. yes to only question 2). However, if the worker answered NO to question 2, AND YES to any one of the other questions, then they should not enter the workplace.

- If any of the answers to these screening questions change during the day, this screening result is no longer valid, and the worker will need to screen again.
- Businesses and organizations should keep records of these screening results. Records must comply with any applicable retention and privacy requirements and may be requested by the local public health unit to support case and contact tracing in the event of an outbreak.

## Note:

For those workers whose work responsibilities involve traveling to multiple locations as part of their work day or shift (e.g., delivery truck drivers, take-out, grocery, prescription delivery staff, etc.), it is the responsibility of the worker's employer to conduct the screening and not that of the receiving business organization or individual. However, such screening may not exempt a worker from being screened by another organization/workplace if the worker is seeking entry into different types of premises (e.g., food deliveries to a long-term care home, and to other places or households).

## Resources:

- [COVID-19 \(coronavirus\) in Ontario](#) webpage (find a testing location, check your results, how to stop the spread of the virus).
- Ministry of Labour, Training and Skills Development's [Resources to prevent COVID-19 in the workplace](#).