

Screening Tool:

PRHC Staff - Travelled to a Country Identified/Based on Transmission

Name (print): _____ Dept: _____ Phone: _____

Country of Travel: _____ Return to Canada Date: _____ DOB: _____

Staff must complete and submit to Occupational Health Safety & Wellness (OHSW) on day 7 and on day 14 or earlier if any symptoms develop.

Week One Monitoring							
	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Do you have a new/worse cough or shortness of breath?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have a temperature of $\geq 38^{\circ}\text{C}$? <i>*Note, taken twice daily and record temperature</i>	Yes <input type="checkbox"/> $^{\circ}\text{C}$ No <input type="checkbox"/> $^{\circ}\text{C}$	Yes <input type="checkbox"/> $^{\circ}\text{C}$ No <input type="checkbox"/> $^{\circ}\text{C}$	Yes <input type="checkbox"/> $^{\circ}\text{C}$ No <input type="checkbox"/> $^{\circ}\text{C}$	Yes <input type="checkbox"/> $^{\circ}\text{C}$ No <input type="checkbox"/> $^{\circ}\text{C}$	Yes <input type="checkbox"/> $^{\circ}\text{C}$ No <input type="checkbox"/> $^{\circ}\text{C}$	Yes <input type="checkbox"/> $^{\circ}\text{C}$ No <input type="checkbox"/> $^{\circ}\text{C}$	Yes <input type="checkbox"/> $^{\circ}\text{C}$ No <input type="checkbox"/> $^{\circ}\text{C}$
Do you have diarrhea?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have vomiting?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
IF YOU ANSWER YES TO ANY OF THE ABOVE, PLEASE CONTACT YOUR LOCAL PUBLIC HEALTH AND NOTIFY OHSW.							
Week Two Monitoring							
	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14
Do you have a new/worse cough or shortness of breath?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have a temperature of $\geq 38^{\circ}\text{C}$? <i>*Note, taken twice daily and record temperature</i>	Yes <input type="checkbox"/> $^{\circ}\text{C}$ No <input type="checkbox"/> $^{\circ}\text{C}$	Yes <input type="checkbox"/> $^{\circ}\text{C}$ No <input type="checkbox"/> $^{\circ}\text{C}$	Yes <input type="checkbox"/> $^{\circ}\text{C}$ No <input type="checkbox"/> $^{\circ}\text{C}$	Yes <input type="checkbox"/> $^{\circ}\text{C}$ No <input type="checkbox"/> $^{\circ}\text{C}$	Yes <input type="checkbox"/> $^{\circ}\text{C}$ No <input type="checkbox"/> $^{\circ}\text{C}$	Yes <input type="checkbox"/> $^{\circ}\text{C}$ No <input type="checkbox"/> $^{\circ}\text{C}$	Yes <input type="checkbox"/> $^{\circ}\text{C}$ No <input type="checkbox"/> $^{\circ}\text{C}$
Do you have diarrhea?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have vomiting?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
IF YOU ANSWER YES TO ANY OF THE ABOVE, PLEASE CONTACT YOUR LOCAL PUBLIC HEALTH AND NOTIFY OHSW.							
Contact Information:							
OHSW – cholme@prhc.on.ca or ohswcentre@prhc.on.ca							
Local Public Healths:							
<ul style="list-style-type: none"> • Peterborough Public Health 705-743-1000 • Haliburton, Kawartha, Pineridge (HKPR) District Health Unit 1-866-888-4577 • Hastings Prince Edward Public Health 613-394-4831 • Simcoe Muskoka District Health Unit 705-721-7520 							