

|  |
| --- |
|  **Required Screening Questions – For Individuals Who Are 18 Years of Age and Older.** |
| **1.** | Are you currently experiencing any one of the symptoms below that are new or worsening? Symptoms should not be chronic or related to other known causes or conditions. Please check ☑ any of these symptoms that apply to you at this time. |
| [ ]  Yes [ ]  No | Cough or barking cough (croup) | Not related to asthma, post-infectious reactive airways, COPD, or other known causes or conditions you already have |
| [ ]  Yes [ ]  No | Decrease or loss of smell or taste | Not related to seasonal allergies, neurological disorders, or other known causes or conditions you already have |
| [ ]  Yes [ ]  No | Difficulty swallowing | Painful swallowing not related to other known causes or conditions you already have |
| [ ]  Yes [ ]  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 |
| [ ]  Yes [ ]  No | Extreme tiredness | Unusual, fatigue, lack of energy (not related to depression, insomnia, thyroid dysfunction, or other known causes or conditions you already have) |
| [ ]  Yes [ ]  No | Falling down often | For older people |
| [ ]  Yes [ ]  No | Fever and/or chills | Temperature of 37.8 degrees Celsius/100 degrees Fahrenheit or higher |
| [ ]  Yes [ ]  No | Headache | Unusual, long-lasting, not related to tension-type headaches, chronic migraines, or other known causes or conditions you already have |
| [ ]  Yes [ ]  No | Muscle aches | Unusual, long-lasting (not related to a sudden injury, fibromyalgia, or other known causes or conditions you already have) |
| [ ]  Yes [ ]  No | Pink eye | Conjunctivitis not related to reoccurring styes or other known causes or conditions you already have |
| [ ]  Yes [ ]  No | Runny orstuffy/congested nose | Not related to seasonal allergies, being outside in cold weather, or other known causes or conditions you already have |
| [ ]  Yes [ ]  No | Shortness of breath | Not related to asthma or other known causes or conditions you already have |
| [ ]  Yes [ ]  No | Sore throat | Not related to seasonal allergies, acid reflux, or other known causes or conditions you already have |

|  |  |  |
| --- | --- | --- |
| 2. | [ ]  Yes [ ]  No | Has a doctor, health care provider, or public health unit told you that you should currently be isolating (staying at home)? |
| 3. | [ ]  Yes [ ]  No | In the last 14-days, have you been identified as a "close contact" of someone who currently has COVID-19? |
| 4. | [ ]  Yes [ ]  No | In the last 14-days, have you received a COVID Alert exposure notification on your cell phone? If you already went for a test and got a negative result, select "No." |
| 5. | [ ]  Yes [ ]  No | In the last 14 days, have you travelled outside of Canada?If you are exempted from federal quarantine as per Group Exemptions, Quarantine Requirements under the *Quarantine Act*, select "No." |
| **PAGE 1 OF 2 (OVER)** |

**Results of Screening Questions:**

* If you answered **NO to all questions from 1 through 5**, welcome to Beauty-Full Spa for your scheduled appointment. No Walk-ins are permitted during the Pandemic. Please complete the required Contract Tracings information at the bottom of this page.
* If you answered **YES to any questions from 1 through 5**, you cannot at this time enter Beauty-Full Spa & Weight Loss Treatment Centre Inc. The Ontario Ministry of Health advises you to go home to self-isolate immediately and contact your health care provider or Telehealth Ontario (1 866-797-0000) to get advice or an assessment, including if they need a COVID-19 test.
* If any of the answers to these screening questions change during the day, this screening result is no longer valid, and you may need to screen again, wherever necessary.
* Any record created as part of your screening may only be disclosed as required by law. By law, Beauty-Full Spa & Weight Loss Treatment Centre Inc. is only required to keep this test for one (1) month, after which time passed, it will be destroyed.

**Resources:** (1) <https://covid-19.ontario.ca/> webpage (find a testing location, check your results, how to stop the spread of the virus); (2) Ministry of Labour, Training and Skills Development's <https://www.ontario.ca/page/resources-prevent-covid-19-workplace>.

This form has been modified with the permission given within the original document. The original document from the Ontario Office of the Chief Medical Officer of Health, Version 2, February 10, 2021, is entitled Covid-19 Screening Tool for Businesses and Organization (Screening Patrons).

The information below will be used only in the event Contact Tracing is required. At such time this form will be given to the Durham Regional Board of Health for contact tracing.

I affirm that I am over the age of eighteen (18) or have the consent of my parent or legal guardian, evidenced by their signature on the face of this COVID-19 Client Prescreen, Waiver and Contact Tracing Form. I have carefully read the above and thoroughly understand its terms and meaning and know of no reason why they are not free and competent to undertake the services of this business that I have requested.

**The date of my visit today is** MM – DD – YR, for an appointment time of \_\_ \_\_\_.

**For contact tracing purposes, you must supply name, address, email, cell number and DOB.**

|  |  |  |  |
| --- | --- | --- | --- |
| CLIENT'S **(BLOCK PRINT NAME):** | CLIENT'S SIGNATURE: | CELL NUMBER:  | EMAIL ADDRESS **(BLOCK PRINT):** |
| Address: | CITY:  | PROV.:  | POSTAL CODE | DATE OF BIRTH:MM/DD/YR |

If you are a minor under 18, please have your parent or guardian complete the section below. However, you are required to complete the section above, with no signature required.

|  |  |  |
| --- | --- | --- |
| **PARENT OR GUARDIAN (IF A MINOR):** | **SIGNATURE:**  | **ADDRESS:** |
| (If applicable – please print in block print your name) | (If different from the one stated above for the Client/Client) |
| **CITY:** | **PROV:** | **POSTAL CODE:** | **CELL TELEPHONE #:** | **EMAIL ADDRESS (BLOCK PRINT):** |

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Beauty-Full Spa & Weight Loss Treatment Centre Inc., 931 Liverpool Rd, Pickering ON Canada, L1W 1S7

Telephone 905-420-0020 Text 647-891-2636 Email info@beautyfullspa.ca www.beautyfullspa.ca