CKP COVID-19 HEALTH SCREENING CHECKLIST

CKP HEALTH SCREENING ASSESSMENT		
IN THE PAST 14 DAYS, HAVE YOU BEEN IN CONTACT WITH SOMEONE WHO IS CONFIRMED TO HAVE COVID-19?	**YES**	**NO**
IN THE PAST 14 DAYS, HAVE YOU BEEN IN A SETTING IDENTIFIED AS A RISK OF ACQUIRING COVID-19, SUCH AS A FLIGHT, A WORKPLACE WITH A KNOWN CLUSTER OF COVID-19 CASES, OR AN EVENT?	**YES**	**NO**
IN THE PAST 14 DAYS, HAVE YOU TRAVELLED OUTSIDE OF MANITOBA RESTRICTED JURISDICTIONS? (The area defined as travel outside of Canada and east of Terrace Bay, Ontario)	**YES**	**NO**

A. Are you currently suffering from or experiencing any of the following symptoms? If yes, please indicate any or all of the symptoms.			
NOTE: Pre-existing medical condition is a medical condition you are aware of and is unrelated to COVID-19. (For example: allergies, sinus issues, migraine headaches, or symptoms related to side effect(s) from medication, etc.)			
NON-PRODUCTIVE (DRY) COUGH	**YES**	**NO**	**Pre-Existing**
SHORTNESS OF BREATH OR BREATHING DIFFICULTIES	**YES**	**NO**	**Pre-Existing**
FEVER >38° OR SUBJECTIVE FEVER	**YES**	**NO**	**Pre-Existing**
LOSS OF TASTE OR LOSS OF SMELL	**YES**	**NO**	**Pre-Existing**
VOMITING OR DIARRHEA FOR MORE THAN 24 HOURS	**YES**	**NO**	**Pre-Existing**
B. Do you have onset or new of any of the two symptoms listed below?			
FATIGUE	**YES**	**NO**	**Pre-Existing**
NAUSEA OR LOSS OF APPETITE	**YES**	**NO**	**Pre-Existing**
SORE THROAT OR HOARSE VOICE	**YES**	**NO**	**Pre-Existing**
MUSCLE OR BODY ACHES	**YES**	**NO**	**Pre-Existing**
HEADACHE	**YES**	**NO**	**Pre-Existing**
RUNNY NOSE	**YES**	**NO**	**Pre-Existing**
SKIN RASH OF UNKNOWN CAUSE	**YES**	**NO**	**Pre-Existing**
CONJUNCTIVITIS (PINK EYE)	**YES**	**NO**	**Pre-Existing**

***If your response to any of the questions listed above is "YES", access to CKP Mill Site will be denied and you must contact your supervisor. Once contact is made, your supervisor will inform you to contact Manitoba Health Links for further direction.**

***If the response to all questions listed above is "NO" or if Pre-Existing, this form is to be returned to your supervisor daily prior to start of shift.**

I attest that the answers I have provided are honest and accurate.

NAME: *(print)* **DATE:**

SIGN:

DEPARTMENT: **COMPANY:**

SUPERVISOR:

Please check one of the following

CKP EMP # ☐

CONTRACTOR ☐

Note: All personnel required to complete the checklist daily. Please remember to take a copy of the CKP Health Screening Checklist at the end of each shift.