Medical and Non-Medical Observers, Vendors Level 2 or 3, Media or Authorized Guest
SELF–SCREENING HEALTH EVALUATION

In a hospital setting, there are several childhood and communicable diseases, which may pose a health risk to patients and/or staff members (e.g. COVID-19, chicken pox, influenza, viral diarrhea, etc.). You are required to answer these questions before your visit to the University Health Network and its affiliates.

INSTRUCTIONS:

The content of this evaluation is strictly confidential. This questionnaire is for self-screening purposes only, and is to be reviewed and retained by the Observerships, Authorized Guest, and Vendor Office at UHN.

1. Answer the questions listed below. All questions are mandatory.
2. If you answer 'NO' to the vaccine question, you will not be able to observe at the hospital as scheduled.

VACCINATION ATTESTATION	**YES**	**NO**
I AM VACCINATED AGAINST; COVID-19 (SARS-CoV-2), MEASLES, MUMPS, RUBELLA (GERMAN MEASLES) AND VARICELLA (CHICKEN POX), OR AM OTHERWISE KNOWN TO BE IMMUNE TO THESE INFECTIONS	☐	☐

DURING THE PAST MONTH, HAVE YOU BEEN EXPOSED TO ANYONE WHO HAS THE FOLLOWING DISEASES?

	YES	**NO**		**YES**	**NO**
TUBERCULOSIS	☐	☐	RUBELLA (GERMAN MEASLES)	☐	☐
MEASLES (RED MEASLES)	☐	☐	VARICELLA (CHICKEN POX)	☐	☐
MUMPS	☐	☐	WHOOPING COUGH	☐	☐

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?

	YES	**NO**		**YES**	**NO**
HEADACHE	☐	☐	RASH	☐	☐
FEVER	☐	☐	CHILLS	☐	☐
NAUSEA / VOMITING / DIARRHEA	☐	☐	NEW OR WORSEING COUGH	☐	☐
EYE PAIN OR PINK EYE (CONJUNCTIVITIS)	☐	☐	SORE THROAT / DIFFICULTY SWALLOWING	☐	☐
RUNNY OR STUFFY NOSE WITH ANOTHER CAUSE	☐	☐	DIFFICULTY BREATHING OR SHORTNESS OF BREATH	☐	☐
DECREASE OF LOSS OF SENSE OF SMELL OR TASTE	☐	☐	UNEXPLAINED FATIGUE, MALAISE, OR MUSCLE ACHES	☐	☐

IN THE PAST 14 DAYS:	**YES**	**NO**
DID YOU HAVE CLOSE CONTACT WITH ANYONE WHO HAD AN ACUTE RESPIRATORY ILLNESS?	☐	☐
DID YOU HAVE A CONFIRMED CASE OF COVID-19 OR WERE YOU IN CLOSE CONTACT WITH SOMEONE WHO HAD COVID-19?	☐	☐

If you answered 'yes' to any of the above, you will not be able to attend and participate in activities at the University Health Network and its affiliates as scheduled.

	YES	**NO**
I am confirming that I have notified my Employer or Educational Institution when applying for an Observership, or Vendor Level 2 or 3, or Media or Authorized Guest Privileges to advise them I am requesting access and coverage under their blanket attestation for COVID-19 vaccination and applicable policies.	☐	☐

By signing this form, I certify that this information is up to date and that UHN will not be responsible for any illness contracted during the visit. I also understand that I will be required to screen upon entry to UHN and its affiliates for COVID-19 and provide proof of vaccination. I understand if I am unable to meet the requirements that I will be denied access.

Signature _____ **Print name** _____ **Date** _____