St. Marys Farmers' Market
Box 1537 St. Marys, ON N4X 1B9
stmarysfarmersmarket92@gmail.com
COVID-19 Screening Questionnaire for Vendors

Vendor Name: _____ **Market Date:** _____

Name of Stall Operator(s): _____

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

• fever/feverish	Yes	No
• new, or existing cought and difficulty breathing	Yes	No
• shorteness of breath (even when sitting or walking regularly)	Yes	No
• decrease of loss of smell or taste	Yes	No
• sore throat	Yes	No
• difficulty swallowing	Yes	No
• pink eye	Yes	No
• runny or congested nose	Yes	No
• unusual headache	Yes	No
• nausea/vomiting, diarrhea, stomach pain	Yes	No
• unusual level of fatigue	Yes	No
• falling down often (older people)	Yes	No

2. Have you traveled outside of Canada in last 14 days? Yes No

3. Have you had close contact with a person with acute repiratory illness who has been outside Canada in the last 14 days? Yes No

4. 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

5. Has a doctor, health care provider, or public health unit told you that you should currently be isolating (staying at home)? Yes No

Signature:_____ Date:_____