

COVID 19 Required Screening Questions

1. Do any of the following apply to you?

- I am fully vaccinated* against COVID-19 (it has been 14 days or more since your final dose of either a two-dose or a one-dose vaccine series)
- I have tested positive for COVID-19 in the last 90 days (and since been cleared by the local public health unit)

If Yes, skip questions 7-10.

Personal health information is not collected when you complete this screening tool.

The purpose of this question is to provide accurate isolation instructions which are based on vaccination status.

2. Are you currently experiencing one or more of the symptoms below that are new or worsening? Symptoms should not be chronic or related to other known causes or conditions.

The symptoms listed here are the symptoms most commonly associated with COVID19. If you have these symptoms, you should isolate and seek testing.

Please note that rapid antigen testing is not to be used for those with symptoms of COVID-19 or for contacts of known COVID-19 cases.

* A person is fully vaccinated against COVID-19 if,

(a) they have received,

(i) the full series of a COVID-19 vaccine authorized by Health Canada, or any combination of such vaccines,

(ii) one or two doses of a COVID-19 vaccine not authorized by Health Canada, followed by one dose of a COVID-19 mRNA vaccine authorized by Health Canada, or

(iii) three doses of a COVID-19 vaccine not authorized by Health Canada; and

(b) they received their final dose of the COVID-19 vaccine at least 14 days before seeking access to the premises.

Do you have one or more of the following symptoms? Circle one:

Yes

No

- Fever and/or chills Temperature of 37.8 degrees Celsius/100 degrees Fahrenheit or higher
- Cough or barking cough (croup) - Not related to asthma, post-infectious reactive airways, COPD, or other known causes or conditions you already have
- Shortness of breath - Not related to asthma or other known causes or conditions you already have
- Decrease or loss of smell or taste - Not related to seasonal allergies, neurological disorders, or other known causes or conditions you already have

FOR ADULTS 18 YEARS OF AGE OR OLDER

- Fatigue, lethargy, malaise and/or muscle aches/joint pain, - Unusual tiredness, lack of energy (not related to depression, insomnia, thyroid dysfunction, or other known causes or conditions you already have)

NOTE: If you received a COVID-19 vaccination in the last 48 hours and are only experiencing mild fatigue, muscle aches, and/or joint pain that only began after vaccination, select "No."

FOR CHILDREN UNDER 18 YEARS OF AGE

Nausea, vomiting and/or diarrhea - Not related to irritable bowel syndrome, anxiety, menstrual cramps, or other known causes or conditions you already have

3. In the last 14 days, have you travelled outside of Canada AND been advised to quarantine (as per the federal quarantine requirements)? Circle one:

Yes

No

4. Has a doctor, health care provider, or public health unit told you that you should currently be isolating (staying at home)? This can be because of an outbreak or contact tracing. Circle one:

Yes

No

5. In the last 10 days, have you been identified as a "close contact" of someone who currently has COVID-19? Circle one:

If public health has advised you that you do not need to self-isolate, select "No."

Yes

No

6. In the last 10 days, have you tested positive on a rapid antigen test or a homebased self-testing kit? Circle one:

If you have since tested negative on a lab-based PCR test, select "No."

Yes

No

7. In the last 10 days, have you received a COVID Alert exposure notification on your cell phone? Circle one:

If you have since tested negative on a lab-based PCR test, select "No."

Yes

No

8. In the last 14 days, has someone in your household (someone you live with) travelled outside of Canada AND been advised to quarantine (as per the federal quarantine requirements)? Circle one:

Yes

No

9. In the last 10 days, has someone in your household (someone you live with) been identified as a "close contact" of someone who currently has COVID-19 AND advised by a doctor, healthcare provider or public health unit to self-isolate?

Yes

No

10. Is anyone you live with currently experiencing any new COVID-19 symptoms and/or waiting for test results after experiencing symptoms? Circle one:

Children (<18 years old): fever and/or chills; cough or barking cough; shortness of breath; decrease or loss of taste or smell; nausea, vomiting and/or diarrhea

Adults: (≥18 years old): fever and/or chills; cough or barking cough; shortness of breath; decrease or loss of taste or smell; tiredness; muscle aches.

If the individual experiencing symptoms received a COVID-19 vaccination in the last 48 hours and is only experiencing mild fatigue, muscle aches, and/or joint pain that only began after vaccination, select "No."

Yes

No

I agree to the following:

- Based on above mentioned screening questions, the salon may refuse entry to the establishment and require appointment to be rescheduled to a date in which the screening questions constitute that isolation is not required.

- I affirm that I, as well as household members, have not been diagnosed with COVID-19 within the last 30 days.

- I understand the COVID-19 virus has an incubation period during which carriers of the virus may not show symptoms & still be highly contagious.

- I understand that due to the frequency of visits of other clients, the characteristics of the virus, and the characteristics of these services, that I have an elevated risk of contracting the virus simply by being in the establishment.

I agree to disclose any changes to the above declaration to Pretty in Wink Lash Boutique upon future appointments and re-sign waiver as requested.

I, knowingly and willingly consent to have services offered by Pretty in Wink Lash Boutique, during the pandemic and will not hold Pretty in Wink Lash Boutique, its owners or anyone working for or residing in this establishment, liable for the possibility of contacting COVID-19. I hereby release and agree to hold Pretty in Wink Lash Boutique, its owners, and/or those residing in the establishment, harmless from, and waive on behalf of myself, my heirs, and any personal representatives any and all causes of action, claims, demands, damages, costs, expenses and compensation for damage or loss to myself and/or property that may be caused by any act, or failure to act of the salon, or that may otherwise arise in any way in connection with any services received

from Pretty in Wink Lash Boutique. I understand that this release discharges Pretty in Wink Lash Boutique, its owners, and/or those residing in the establishment, from any liability or claim that I, my heirs, or any personal representatives may have against the salon with respect to any bodily injury, illness, death, medical treatment, or property damage may arise from, or in connection to, any services received from Pretty in Wink Lash Boutique. This liability waiver and release extends to the salon together with all owners, partners, residents of the establishment and employees.

Client

Signature _____

Date _____

