Daily Health Screening

Name:_____ Division:_____

Daily Health Check			
Symptoms of illness	Does your child have any of the following symptoms?	CIRCLE ONE	
	Fever	YES	NO
	Chills	YES	NO
	Cough or worsening chronic cough	YES	NO
	Shortness of breath	YES	NO
	Sore throat	YES	NO
	Runny nose/Stuff nose	YES	NO
	Headache	YES	NO
	Fatigue	YES	NO
	Diarrhea	YES	NO
	Loss of appetite	YES	NO
	Nausea and vomiting	YES	NO
	Muscle aches	YES	NO
	Conjunctivitis (pink eye)	YES	NO
	Dizziness, confusion	YES	NO
	Abdominal pain	YES	NO
	Skin rashes or discoloration of fingers and toes	YES	NO
International Travel	Have you or anyone in your household returned from travel outside Canada in the last 14 days?	YES	NO
Confirmed Contact	Are you or is anyone in your household a confirmed contact of a person confirmed to have COVID-19?	YES	NO

If you answered "YES" to any of the questions and the symptoms are not related to a pre-existing condition (e.g. allergies) your child should **NOT** come to school.

If they are experiencing any symptoms of illness, contact a health-care provider for further assessment. This includes 8-1-1, or a primary care provider like a physician or nurse practitioner.

If you answered "YES" to questions 2 or 3, use the COVID-19 Self-Assessment Tool to determine if you should be tested for COVID-19.