



# COVID-19 SCREENING PASSPORT

Parent to complete each day and send along  
with child to school

STUDENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

1. Does your child have any of the following new or worsening symptoms?\*



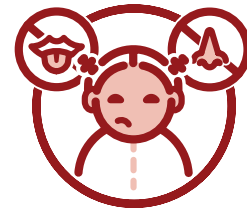
FEVER > 37.8° C



COUGH



DIFFICULTY  
BREATHING



LOSS OF TASTE OR  
SMELL

If "YES": Stay home, self-isolate & get tested or contact your child's health care provider.

2. Does your child have any of the following new or worsening symptoms?\*



SORE THROAT,  
PAINFUL  
SWALLOWING



STUFFY/RUNNY  
NOSE



HEADACHE



NAUSEA,  
VOMITING,  
DIARRHEA



FEELING UNWELL,  
MUSCLE ACHES,  
FEELING TIRED

If "YES" to 1 symptom:

- Stay home for 24 hours once symptom started
- If improving in 24 hours, can return to school. No test needed
- If not improving, or getting worse, self-isolate & get tested

If "YES" to 2 or more symptoms:

- Stay home, self-isolate & get tested or contact child's health care provider

3. Has your child travelled outside of Canada in the past 14 days?

4. Has your child been identified as a close contact of someone with COVID-19?

5. Has your child been instructed to stay home and self-isolate?

If you answered "YES" to questions 3, 4 or 5:

Your child must stay home, self-isolate & follow advice of public health

\*Children who have an existing health condition identified by a health care provider that gives them the symptoms should not answer YES, unless the symptom is new, different or getting worse. Look for changes from your child's normal symptoms.



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*"My child does not have any of the symptoms/risk factors from the previous page."*

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