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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