

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?*



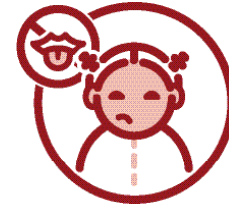
FEVER > 37.8° C



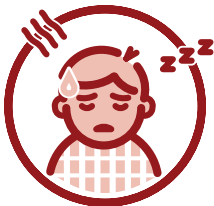
COUGH



DIFFICULTY
BREATHING



LOSS OF TASTE



FEELING UNWELL,
MUSCLE ACHES
OR TIRED



STUFFY OR
RUNNY NOSE



HEADACHE



SORE THROAT OR
PAINFUL
SWALLOWING



NAUSEA,
VOMITING,
OR DIARRHEA

If "YES" to
any symptom:

Stay home, self-isolate + Get tested OR contact a health care provider.

2. Is there a child or sibling in your household who has one or more of the above symptoms?

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

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

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

If you answered "YES" to questions 2, 3, 4 or 5:

Stay home & self-isolate + follow public health advice

*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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