# Daily Health Screening

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| **Daily Health Check** | | | |
| **Student Name: Teacher/Div:** | | | |
| 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.