

COVID-19 INFORMATION

Screening Questionnaire

PARENTS/GUARDIANS/STUDENTS MUST USE THIS QUESTIONNAIRE DAILY TO DECIDE IF THE STUDENT SHOULD ENTER THE SCHOOL

Risk Assessment: Initial Screening Questions

		CIRCLE ONE	
1.	Do you, or your child attending the program, have any of the below symptoms:	YES	NO
	• Fever	YES	NO
	• Cough	YES	NO
	• Shortness of Breath / Difficulty Breathing	YES	NO
	• Sore throat	YES	NO
	• Chills	YES	NO
	• Painful swallowing	YES	NO
	• Runny Nose / Nasal Congestion	YES	NO
	• Feeling unwell / Fatigued	YES	NO
	• Nausea / Vomiting / Diarrhea	YES	NO
	• Unexplained loss of appetite	YES	NO
	• Loss of sense of taste or smell	YES	NO
	• Muscle/ Joint aches	YES	NO
	• Headache	YES	NO
	• Conjunctivitis (Pink Eye)	YES	NO
2.	Has the person attending the activity/facility travelled outside of Canada in the last 14 days?	YES	NO
3.	Have you/your child had close unprotected* contact (face-to-face contact within 2 meters/6 feet) with someone who has travelled outside of Canada in the last 14 days and who is ill**?	YES	NO
4.	Have you/your child attending the program or activity had close unprotected* contact (face-to-face contact within 2 meters/6 feet) in the last 14 days with someone who is ill**?		
5.	Have you/your child or anyone in your household been in close <u>unprotected</u> contact in the last 14 days with someone who is being investigated or confirmed to be a case of COVID-19?	YES	NO

* "unprotected" means close contact without appropriate personal protective equipment (PPE).

If you have answered "Yes" to any of the above questions, please **DO NOT** enter the school at this time. You should stay home and use the [COVID-19 Self-Assessment Tool](#) to determine whether you need to be tested for COVID-19.

If you have answered "No" to all the above questions, you may enter the school.

Student Name (Please Print)

Parent/Guardian/Adult Student Signature

Date: _____