Student Daily Health Check

First Name: _____ **Last Name:** _____

Date: _____ **School:** _____

Parent/Guardian: _____

1. Symptoms of Illness*	**Does your child have any of the following symptoms?**	**CIRCLE ONE**	
	Fever	YES	NO
	Chills	YES	NO
	Cough or worsening of chronic cough	YES	NO
	Shortness of breath	YES	NO
	Sore throat	YES	NO
	Runny nose / stuffy nose	YES	NO
	Loss of sense of smell or taste	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 or toes	YES	NO
2. International Travel	Have you or anyone in your household returned from travel outside Canada in the last 14 days?	YES	NO
3. Confirmed Contact	Are you or is anyone in your household a confirmed contact of a person confirmed to have COVID-19?	YES	NO

If your child answered "YES" to any of the questions and the symptoms are not related to a pre-existing condition (e.g. allergies) they should **NOT** come into school. Notify the school office of the absence and if you 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.