Daily Screening Questionnaire

STOP! EVERYONE MUST FILL OUT THIS QUESTIONNAIRE PRIOR TO ADMITTANCE INTO THIS CHILD CARE FACILITY

Do you or your child have any of the following symptoms? ***circle one***

1.	Fever	**YES**	**NO**
2.	Cough / sore throat	**YES**	**NO**
3.	Shortness of breath/ difficulty breathing	**YES**	**NO**
4.	Runny nose/ nasal congestion	**YES**	**NO**
5.	Feeling unwell/ fatigued	**YES**	**NO**
6.	Vomiting/nausea/diarrhea	**YES**	**NO**
7.	Muscle aches	**YES**	**NO**
8.	Headache	**YES**	**NO**
9.	Pink Eye	**YES**	**NO**
10.	Loss of sense of smell/taste	**YES**	**NO**
11.	**In the past 24 hours** has your child been administered any medications (acetaminophen, ibuprofen, homeopathic, etc…)	**YES**	**NO**
12.	Have you, or anyone in your household, travelled outside of Canada in the last 14 days?	**YES**	**NO**
13.	Has anyone in your household been in contact with someone who is suspected, or confirmed to have, COVID-19, in the past 14 days?	**YES**	**NO**

If you have answered **"YES"** to any of these questions, **ENTRY IS NOT PERMITTED.**

Children or staff displaying any of the above symptoms will be required to go home.

Our goal is to minimize the risk of infection to Educators, children and families, so that we can continue to offer this important service. Thank you for your honesty and diligence.

Names (parent and child): _____

Signature: _____ Date: _____