Daily Screening Questionnaire

PLEASE REVIEW THIS QUESTIONNAIRE PRIOR TO ADMITTANCE FOR EACH SESSION

1.	Do you, or your child, or anyone in your household have any of the following symptoms?	**Circle one**	
	• Fever	**YES**	**NO**
	• Cough	**YES**	**NO**
	• Shortness of Breath / Difficulty Breathing	**YES**	**NO**
	• Sore throat	**YES**	**NO**
	• Runny Nose / Nasal Congestion	**YES**	**NO**
	• Feeling unwell / Fatigued	**YES**	**NO**
	• Nausea / Vomiting / Diarrhea	**YES**	**NO**
	• Muscle Aches	**YES**	**NO**
	• Headache	**YES**	**NO**
	• New loss of taste, loss of smell	**YES**	**NO**
2.	Have you or your child, ***in the past 24 hrs*** been administered any medications (acetaminophen, ibuprofen, homeopathic, etc..) to treat any of the symptoms listed above?	**YES**	**NO**
3.	Have you, or anyone in your household traveled outside of Canada in the last 14 days?	**YES**	**NO**
4.	Have you or your children attending the program had close contact (face-to-face contact within 2 meters/6 feet) with someone who is ill with a cough and/or fever?	**YES**	**NO**
5.	Have you or anyone in your household been in contact in the last 14 days with someone who is suspected, tested, or confirmed positive for COVID-19?	**YES**	**NO**

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

Our goal is to minimize the risk of infection to educators, children, and families. Thank you for your diligence and cooperation.

You will be asked to sign off on this questionnaire at drop off.