



# COVID-19 SCREENING PASSPORT

Parent to complete each day and send along  
with child to school

STUDENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**1. Does your child have any of the following new or worsening symptoms?\***



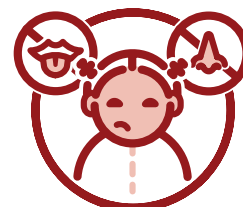
**FEVER > 37.8° C**



**COUGH**



**DIFFICULTY  
BREATHING**



**LOSS OF TASTE OR  
SMELL**

**If "YES":** Stay home, self-isolate & get tested or contact your child's health care provider.

**2. Does your child have any of the following new or worsening symptoms?\***



**SORE THROAT,  
PAINFUL  
SWALLOWING**



**STUFFY/RUNNY  
NOSE**



**HEADACHE**



**NAUSEA,  
VOMITING,  
DIARRHEA**



**FEELING UNWELL,  
MUSCLE ACHES,  
FEELING TIRED**

**If "YES" to 1 symptom:**

- Stay home for 24 hours once symptom started
- If improving in 24 hours, can return to school. No test needed
- If not improving, or getting worse, self-isolate & get tested

**If "YES" to 2 or more symptoms:**

- Stay home, self-isolate & get tested or contact child's health care provider

**3. Has your child travelled outside of Canada in the past 14 days?**

**4. Has your child been identified as a close contact of someone with COVID-19?**

**5. Has your child been instructed to stay home and self-isolate?**

**If you answered "YES" to questions 3, 4 or 5:**

Your child must stay home, self-isolate & follow advice of public health

\*Children who have an existing health condition identified by a health care provider that gives them the symptoms should not answer YES, unless the symptom is **new**, **different** or **getting worse**. Look for changes from your child's normal symptoms.