STOP Covid-19 Screening

If you answer YES to ANY of the following questions, do not send your child to school and consult your health care provider or local Public Health Unit for further instructions:

Is your child and/or any person in your child's household experiencing any of the following new or worsening symptoms associated with COVID-19?

Fever (temperature)

☐YES ☐NO

New or worsening Cough

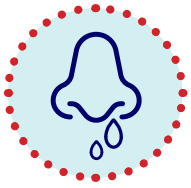
☐YES ☐NO

Shortness of breath, Difficulty breathing

☐YES ☐NO

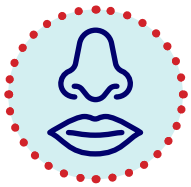
Sore throat, Difficulty swallowing

☐YES ☐NO



Runny nose or nasal congestion

☐YES ☐NO



Loss of sense of taste or smell

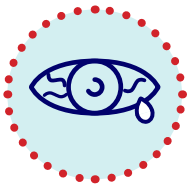
☐YES ☐NO

Nausea, vomiting, diarrhea

☐YES ☐NO

Unexplained fatigue / malaise / chills / headache

☐YES ☐NO



Pink eye (conjunctivitis)

☐YES ☐NO

Has your child, or anyone in your child's household, been in close physical contact with any person who is being "investigated" or has tested positive for COVID-19 during the past 14 days, without wearing the appropriate Personal Protective Equipment?

☐YES ☐NO

Has your child, or anyone in your child's household, travelled outside Canada in the last 14 days?

☐YES ☐NO

Have you and/or any person in your child's household worked in a facility known to be experiencing an outbreak of COVID-19?

☐YES ☐NO

August 31, 2020