COVID-19 Screening and Log Location: _____

Child's Name (First & Last)		Date	Time	Close contact with anyone with respiratory illness	Travelled outside of Ontario in the past 14 days?	Been diagnosed with COVID-19?	Does your child have: (Y) or (N) Fever	New or worsing cough	Shortness of breath, difficulty breathing	Sore throat, difficulty swallowing	Decreaseor loss of taste or smell	Chills	Headache	Fatigue, malaise, muscle aches	Nausea, vomiting, diarrhea, abdominal pain	Pink eye	Runny nos, nasal congestion without other cause	Temperature (< 37.8 c)	Initials
	IN																		
	OUT																		
	IN																		
	OUT																		
	IN																		
	OUT																		
	IN																		
	OUT																		
	IN																		
	OUT																		
	IN																		
	OUT																		