COVID-19 Active Screening Tool for Child

Facility Name: SHKODAY

Form to be completed daily for each **CHILD**

Date	**Name (Last name, first name)**	**Class Room** (Pre-K, Pre, Kin)	**Has a doctor, health care provider, or public health unit told you your child should currently be isolating (staying at home)?**	**In the last 14 days, has your child been identified as a "close contact" of someone who currently has COVID-19 or received a COVID Alert exposure notification on cell phone?**	**Traveled past White River or Manitoba Border?**	**Decrease or loss of smell or taste.** (Not related to other known causes or conditions)	**Cough or barking cough (croup)?**	**Fever or chills with temp over 37.8°C?**	**Shortness of breath?**	**Any of the following new or worsening symptoms not related to other known causes or conditions:** Difficulty breathing, Sore throat, Stuffy/runny/congested nose Headache, Nausea/vomiting/diarrhea Extreme tiredness or muscle aches	**Onset date of first symptom (yy/mm/dd)**	**Comments**
			☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐ No		
			☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐ No		
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