|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Child Care Centre Visitor’s Information Full Name:** | | | | | | | | | | | | | | | | |
| **Organization:** | | | | | **Purpose of visit:** | | | | | | | **Phone #:** | | | | |
| **Time in:** | | | | | **Time out:** | | | | | | | **Email:** | | | | |
| **Screening Questions** | | | | | | | | | | | | | | | | | |
| **Q1: Do you, or any member of your household have any of the following symptoms:** | | | | | | | | | | | | | | | | | |
| * ***Fever*** * ***chills*** * ***cough and*** * ***Difficulty breathing*** | | | | * ***sore throat*** * ***Headaches*** * ***unexplained fatigue/muscle aches*** * ***Loss of sense of taste and smell*** | | | | | | | * ***Abdominal pain*** * ***Diarrhea*** * ***Pink eye*** * ***Runny nose without known cause?*** | | | | | | |
| **Q2: Have you travelled outside of Canada, including the United States, within the last 14 days?**  **Q3: Have you had close contact with a confirmed or probable COVID-19 case?**  **Q4: Have you had close contact with a person with acute respiratory illness who has been outside Canada, including the United States, in the last 14 days?**  **Q5: Have you been taken fever reducing medicine in the last 12 hours?** | | | | | | | | | | | | | | | | | |
| **Date Completed (yyyy-mm-dd)** | **Recorded Temperature (Note: Fever is 38oC/100.4oF and above)** | **Staff Initial** | **RESPONSES TO SCREENING QUESTIONS** | | | | | | | | | | | | | | |
| **Q1** | | | | **Q2** | | **Q3** | | | | **Q4** | | **Q5** | | |
|  |  |  | **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** | **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** | **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** | | | **YES** | **NO** | **YES** | **NO** | |