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| **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** |