



Name of individual being screened: _____

Check applicable box: Child Staff Visitor/Service Provider

Program/Group: _____ Assigned Screener: _____

Time of Arrival: _____

Screening Questions:

All **adults** (staff, visitors, essential service providers) entering the child care space will be denied entry for **any single new or worsening symptom** not related to a previous condition. **Adults denied** must remain home and follow one of the following options;

Contact health care provider, walk-in-clinic **OR**

Contact Niagara Health COVID-19 Assessment Centre to book an appointment for testing

1. Does your participant have any of the following symptoms?

Fever and/or chills (temperature of 37.8 degrees C or greater)	<input type="checkbox"/> No	<input type="checkbox"/> Yes (No Entry)
Cough (more than usual if chronic cough) <i>Not related to other known causes or conditions (ex. Asthma, reactive airway)</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes (No Entry)
Shortness of breath <i>Not related to other known causes or conditions (ex. Asthma, reactive airway)</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes (No Entry)
Decrease or loss of smell or taste <i>Not related to other known causes or conditions (ex. Nasal polyps, allergies, neurological disorders)</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes (No Entry)

2. Does your participant have any of the following **new or worsening** symptoms? *Symptoms should not be chronic or related to other known causes or conditions.*

Sore throat <i>Not related to other known causes or conditions (ex. Post nasal drip, gastroesophageal reflux)</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes (No Entry)
Stuffy nose and/or runny nose <i>Not related to other known causes or conditions (ex. Seasonal allergies, returning inside from the cold, chronic sinusitis unchanged from baseline, reactive airway)</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes (No Entry)
Headache that is new, persistent, unusual, unexplained or long lasting <i>Not related to other known causes or conditions (ex. Tension type headaches, chronic migraines)</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes (No Entry)
Nausea, vomiting and/or diarrhea <i>Not related to other known causes or conditions (ex. Transient vomiting due to anxiety in children, chronic vestibular dysfunction, irritable bowel syndrome, inflammatory bowel disease, side effect of medication).</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes (No Entry)
Fatigue, lethargy, muscle aches or malaise (general feeling of being unwell, lack of energy, extreme tiredness, poor feeding in infants) that is unusual or unexplained.	<input type="checkbox"/> No	<input type="checkbox"/> Yes (No Entry)



Not related to other known causes or conditions (ex. Depression, insomnia, thyroid dysfunction, anemia).		
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3. Has your participant travelled outside of Canada in the past 14 days?

- No
- Yes (no entry)

4. Has your participant been identified as a close contact of someone who is confirmed as having COVID-19 by your local public health unit (or from the COVID Alert app?)

- No
- Yes (no entry)

5. Has your participant been directed by a health care provider including public health official to isolate?

- No
- Yes (no entry)

Results of Screening Questions:

If you answered “YES” to any of the symptoms included under question 1:

- Your child should stay home to isolate immediately
- Contact your child’s health care provider for further advice or assessment, including if your child needs a COVID-19 test or other treatment.

If you answered “Yes” to only one of the symptoms included under question 2:

- Your child should stay home for 24hrs from when the symptom started
- If the symptom is improving, your child may return to care when they feel well enough to do so. A negative COVID-19 test IS NOT required to return.
- If the symptom persists or worsens, contact your child’s health care provider for further advice or assessment, including if your child needs a COVID-19 test or other treatment.

If you answered “Yes” to two or more of the symptoms included under question 2:

- Your child should stay home to isolate immediately
- Contact your child’s health care provider for further advice or assessment, including if your child needs a COVID-19 test or other treatment.

If you answered “Yes” to question 3, 4, or 5:

- Your child should stay home to isolate immediately and follow the advice of public health
- If your child develops symptoms, you should contact your local public health unit or health care provider for further notice.

Hours of Operation	Contact	Phone
9:15a.m. – 8:30p.m	Public Health COVID Hotline	905-688-8248 Press 7; Press 2

Signature of screener: _____

Date: _____