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Roots Covid-19 Pre-Screening Questionnaire

Parent First and Last Name:	Date:	
Child First and Last Name:	Time:	
1. Are you or your child experiencing any of the following symptoms?	YES	NO
a. Fever of 37.8 C or higher		
b. Cough		
c. Difficulty Breathing or Shortness of Breath		
d. Nausea or vomiting		
e. Chest pain		
f. Loss of taste or smell		
g. Severe fatigue or feeling generally unwell		
h. Diarrhea		
2. In the last 14 days have you:	YES	NO
Traveled Outside of Canada:		
Been in close contact with someone who has a confirmed or probable case of COVID-19		
Been in close contact with a person with an acute respiratory illness who has been out of country within 14 days prior to their illness onset?		
3. We agree:	YES	NO
To practice strict social distancing, during both-drop/off and pick up times- this means following public health recommendations regarding maintaining at least a 2-metre distance from other parents		
To let the supervisor/director to measure my and my child's fever daily		
To be visually screened by the supervisor/director for any obvious physical symptoms.		
4. We confirm:	YES	NO
That we do not have symptoms of Covid-19 and not at risk to your staff.		
Signature:		
If you have answered Yes to any of the above questions in points 1 and 2, please delay your attendance AND contact your healthcare provider, or Telehealth Ontario at 1-866-797-0000		