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| **Daily Health Assessment** | | | |
| 1. **Symptoms of Illness** | **Does your child have any of the following symptoms?** | **Please select:**  **Yes or No** | |
| Fever | * Yes | * No |
| Chills | * Yes | * No |
| Cough or worsening of chronic cough | * Yes | * No |
| Shortness of breath | * Yes | * No |
| Loss of sense of smell or taste | * Yes | * No |
| Diarrhea | * Yes | * No |
| Nausea and vomiting | * Yes | * No |
| 1. **International Travel** | Have you returned from travel outside of Canada in the last 14 days? | * Yes | * No |
| 1. **Confirmed Contact** | Are you a confirmed contact of a person confirmed to have COVID-19? | * Yes | * No |

**If you answered “Yes” to one of the symptoms above (excluding fever),** your child should stay home for 24 hours from when the symptom started. If the symptom improves, they may return to school when they feel well enough. If the symptom(s) persists or worsens, seek a health assessment.

**If you answered “Yes” to two of the symptoms above or your child has a fever,** seek a health assessment. A health assessment includes calling 8-1-1 or visiting or speaking with a primary care provider like a physician or nurse practitioner. If a health assessment is required, your child should not return to school until COVID-19 has been excluded and their symptoms have improved.

**2. International Travel:** Has your child returned from travel outside of Canada in the last 14 days?

**3. Confirmed Contact:** Is your child a confirmed contact of a person confirmed to have COVID-19?

If you answered “YES” to questions 2 or 3, use the COVID-19 Self-Assessment Tool (https://www.thrive.health/bcself-assessment-tool) to determine if you should seek testing for COVID-19.

Parent Caregiver Name: Parent Contact Number:

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Child(ren) Name(s):

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Date: