**QCMC Daily Participant Screening Form**

In the past 24 hours, has your child experienced the following cold, flu or COVID-19 like symptoms:

Fever higher than 38°C YES [ ] NO [ ]

Chills YES [ ] NO [ ]

Cough YES [ ] NO [ ]

Loss of sense of smell or taste YES [ ] NO [ ]

Difficulty Breathing YES [ ] NO [ ]

Sore Throat YES [ ] NO [ ]

Loss of appetite YES [ ] NO [ ]

Extreme fatigue or tiredness YES [ ] NO [ ]

Headache YES [ ] NO [ ]

Body aches YES [ ] NO [ ]

Nausea or vomiting YES [ ] NO [ ]

Diarrhea YES [ ] NO [ ]

If you answered YES to any symptoms above, your child will not be permitted to attend camp.

Please self-isolate at home, and contact your doctor or primary care provider for further instructions.

If you answered NO to **all** of the above, please complete the next part of the form:

In the past 14 days, has your child:

|  |  |  |
| --- | --- | --- |
| Travelled to any countries outside of Canada (including the United States): | YES [ ] | NO [ ] |
| Had close contact with a person diagnosed with COVID-19: | YES [ ] | NO [ ] |
| Had close contact with a person under investigation for COVID-19: | YES [ ] | NO [ ] |
| Been instructed to self isolate by a doctor, nurse or public health official: | YES [ ] | NO [ ] |

If you answered YES to any of the above, your child will not be permitted to attend camp until cleared by a public health official.

If you have answered NO to **all** of the above, have a great day at camp!

I have answered above with regards to my child’s health at the beginning of the day, prior to their arrival at camp.

Participant’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_