Name: _____ Date: _____

ISAND - SCREENING TOOL

Please Complete Before Appointment

1. Does the child have any of the following symptoms?*


Fever > 37.8°C


Cough


Difficulty breathing


Loss of taste


Feeling unwell, muscle aches or tired


Stuffy or runny nose


Headache


Sore throat or pain swallowing


Nausea, vomiting or diarrhea

If "YES" to any symptom:  **Stay home & self-isolate** +  **Get tested** **Or**  **Contact a health care provider**

2. Is there a child or sibling in your household who has one or more of the above symptoms? ☐ Yes ☐ No

3. Has the child travelled outside of Canada in the past 14 days? ☐ Yes ☐ No

4. Has the child been notified as a close contact of someone with COVID-19? ☐ Yes ☐ No

5. Has the child been told to stay home and self-isolate? ☐ Yes ☐ No

If "YES" to Questions 2,3,4 or 5:  **Stay home & self-isolate** +  **Follow public health advice**

*Children who have an existing health condition identified by a health care provider that gives them the symptoms should not answer YES, unless the symptom is **new, different** or **getting worse.** Look for changes from your child's normal symptoms.

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