KidsAbility™

Screening Questions

1. Are you or your child currently experiencing any of these symptoms? (Choose any/all that are **new, worsening,** and not related to other known causes or conditions you already have)?

Yes ◯ **No** ◯

- Fever and/or chills
- Cough or barking cough (croup)
- Shortness of breath
- Decrease of loss or taste or smell
- Muscle aches/joint pain
- Extreme tiredness
- Sore throat
- Runny or stuffy/congested nose
- Headache
- Nausea, vomiting and/or diarrhea
- Abdominal pain
- Pink Eye
- Decreased or no appetite (young children)

Note: Answer "No" if you or your child/children do not have a fever and your symptoms have been improving for at least 24 hours or 48 hours if you have nausea, vomiting and/or diarrhea.

2. Have you or your child/children been told from a doctor, health care provider, public health unit or federal border agent that you should currently be quarantining, isolating, staying at home, or not attending school or childcare?

Yes ◯ **No** ◯

3. In the last 10 days have you or your child/children tested positive for COVID 19? (This includes a positive COVID 19 test result on a lab-based PCR test, rapid molecular test, rapid antigen test or home-based self testing kit.)

Yes ◯ **No** ◯

Note: Select "No" if the individual who tested positive is fever free and has symptoms improving for at least 24 hours or 48 hours for GI symptoms (nausea, vomiting, diarrhea) and they have ended their isolation.

I acknowledge that I have answered "no" to the above screening questions.

Date: _____

Child's Name: _____

Guardian Name: _____

Guardian Signature: _____