1	Do you have any of the following symptoms which are new or worsened if associated with allergies, chronic or pre-existing conditions: fever, cough, shortness of breath, difficulty breathing, sore throat, and/or runny nose?	**YES**	**NO**
2	Did you have close contact* with a person who has a probable** or confirmed case of COVID-19?	**YES**	**NO**
3	Have you returned to Canada from outside the country (including USA) in the past 14 days?	**YES**	**NO**
4	Did you have close contact* with a person who had an acute respiratory illness that started within 14 days of their close contact* to someone with a probable** or confirmed case of COVID-19?	**YES**	**NO**
5	Did you have close contact* with a person who had an acute respiratory illness who returned from travel outside of Canada in the 14 days before they became sick?	**YES**	**NO**
6	Did you have a laboratory exposure to biological material (i.e. primary clinical specimens, virus culture isolates) known to contain COVID-19?	**YES**	**NO**

*PARENT/GUARDIAN SIGNATURE*_____

*DATE:*_____/_____/_____