



Our Lady of Good Counsel School

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COVID-19 HEALTH & SCREENING FORM

Our Lady of Good Counsel Elementary School reserves the right to refuse admittance to any person on the basis of their responses to the questions posed and information requested by this Form.

Family Name: _____ Parent Signature: _____

Student: _____ Grade: _____ Date: _____ Time: _____

A. In the past 24 hours, have you experienced any of the following?

SORE THROAT	YES __ NO __	SHORTNESS OF BREATH	YES __ NO __
FEVER OR CHILLS	YES __ NO __	LOSE SENSE OF SMELL OR TASTE	YES __ NO __
HEADACHE	YES __ NO __	RUNNY NOSE / STUFFY NOSE	YES __ NO __
FATIGUE	YES __ NO __	DIARRHEA	YES __ NO __
MUSCLE ACHES	YES __ NO __	NAUSEA & VOMITING	YES __ NO __
CONJUNCTIVITIS	YES __ NO __	LOSS OF APPETITE	YES __ NO __
DIZZINESS/CONFUSION	YES __ NO __	ABDOMINAL PAIN	YES __ NO __
SKIN RASH OR DISCOLORATION OF FINGERS OR TOES	YES __	NO __	
COUGH OR WORSENING OF CHRONIC COUGH	YES __	NO __	

Instructions:

If you answered YES to any of the symptoms listed above you will not be admitted to Our Lady of Good Counsel Elementary School.

Please self-isolate at home and contact your primary care doctor for directions.

If you answered NO to all of the above complete section B.

B. In the past 14 days, have you?

HAVE YOU TRAVELED INTERNATIONALLY? YES __ NO __

ARE YOU OR IS ANYONE IN YOUR HOUSEHOLD A CONFIRMED CONTACT OF A PERSON CONFIRMED TO HAVE COVID-19? YES __ NO __

Instructions:

If you answered YES you are not permitted to enter the facilities and should self-quarantine at home for 14 days following close contact with the COVID-19 positive person or return from international travel.

I have signed the above form and I understand that I must CHECK MY CHILD/REN DAILY, prior to entering school, in regards to the above possible symptoms. Should any symptoms appear I will advise the school and keep my child/ren home.