**Name of Child Care** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Page** \_\_\_\_\_ **of** \_\_\_\_\_

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|  | **Demographics** | **Symptoms** | **Testing** |  |  |  |
| Case # (sequentially) | Name(LAST NAME, first name) | Classroom& Days Attending | Sex (M/F/X) | Date of Birth (YYYY/MM/DD) | Parent Name & Phone Number | Onset date of first symptom (yyyy/mm/dd) | Fever/chills | New or worsening cough | Shortness of breath | Sore throat | Difficulty swallowing | Cannot smell or taste | Unexplained fatigue/muscle aches | Altered mental status | Headaches | Croup | Pink eye | Unexplained fast heartbeat | Vomiting/diarrhea/abdominal pain | Runny nose, congestion (in absence of seasonal allergies) | Child recommended to be tested  (Yes /No/ TBC)  | Comments | Date child last attended centre (YYYY/MM/DD) | Date child returned to childcare(YYYY/MM/DD) |
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