COVID-19 Child Care/School Reporting Form

Case ID#:

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| **Caller Information** | | | | | | |
| Name and address of reporting Centre/School: Click here to enter text. | | | | Date: Click here to enter a date. | | |
| Name of Reporting Person: Click here to enter text. | | | | Contact Number: (###) ### - #### | | |
| **Child/Staff Information** | | | | | | |
| Name: Click here to enter text. | | Health Card #: Click here to enter text. | | DOB: YYYY/MM/DD | | Gender:  M F  X |
| Home Address: Click here to enter text. | | | | Client Phone: (###) ### - #### | | |
| Name of parent/guardian (if applicable): Click here to enter text. | | | | Classroom: Click here to enter text. | | |
| City: Click here to enter text. Postal Code: Click here to enter text. | | | | | | |
| Family Physician: Click here to enter text. | | | | | | |
| Comments: Click here to enter text. | | | | | | |
| **Lab Information** | | | | | | |
| Specimen Collected:  NP  Throat  No sample collected Date Collected: YYYY/MM/DD | | | | | | |
| **Signs and Symptoms -** Tick all that apply and specify dates of presentation if known | | | | | | |
| Symptoms | Symptom Onset Date | | Symptoms | | Symptoms Onset Date | |
| Fever (>37.8 C) | YYYY/MM/DD | | Cannot taste or smell | | YYYY/MM/DD | |
| Chills | YYYY/MM/DD | | Pink eye | | YYYY/MM/DD | |
| New or worsening cough | YYYY/MM/DD | | Unexplained fatigue/muscle aches | | YYYY/MM/DD | |
| Shortness of breath | YYYY/MM/DD | | Altered mental status and inattention | | YYYY/MM/DD | |
| Sore throat | YYYY/MM/DD | | Croup | | YYYY/MM/DD | |
| Difficulty swallowing | YYYY/MM/DD | | Unexplained fast heartbeat | | YYYY/MM/DD | |
| Headaches | YYYY/MM/DD | | Nausea/vomiting, diarrhea | | YYYY/MM/DD | |
| Runny nose or nasal   congestion (if not prone to   allergies) | YYYY/MM/DD | | Diarrhea | | YYYY/MM/DD | |
| Sluggishness or lack of appetite/difficulty feeding infants | YYYY/MM/DD | | Other | | YYYY/MM/DD | |
| **Exposures and Travel History** | | | | | | |  |  |
|  | | | | | | |  |  |
| **Exposures 14 days prior to onset:**  Travel  Exposure to lab-confirmed case  High risk contact of a confirmed case  No known exposure  Comments: Click here to enter text. | | | | | | |  |  |
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| **All completed forms to be faxed to the ID Confidential fax line at: 705-733-7738** | | | | | | |

Version 4 Updated: September 1, 2020