Children's Therapy and Family Resource Centre

801 McGill Road, Kamloops, BC V2C 6R1 Phone: (250) 371-4100 Fax: (250) 371-4120
www.kamloopschildrenstherapy.org

Client Screening Checklist

Please read the following statements and answer either yes or no. Please inform the staff member who booked your appointment of your responses, either by sending them a copy of the form or contacting them by email or phone. You will be asked to complete this questionnaire again when you arrive for your scheduled in-person appointment. We will also measure your temperature at that time.

Child's Name:_____ Caregiver Accompanying Child:_____

Date of Birth: _____ Relationship to Child:_____

Today's Date:_____

	Child		Caregiver	
	Yes	No	Yes	No
Do you have a fever or have felt hot or feverish anytime in the last two weeks?				
Do you have any of these symptoms: Dry cough? Shortness of breath? Difficulty breathing? Sore throat? Runny nose? Sneezing? Post-nasal drip?				
Have you experienced a recent loss of smell or taste?				
Does anyone in your household have any of the above symptoms?				
Have you been in contact with any confirmed COVID-19 positive patients, or persons self-isolating because of a determined risk for COVID-19?				
Has anyone in your household returned from travel outside of Canada in the last 14 days?				

If you have any questions about this process, please contact your consultant or call the front desk at 250-371-4100.

Thank you for your cooperation as we work to protect your family and our staff.

Office Use Only:

Recorded Temperature: _____

Date: _____

Signature: _____