COVID-19 SCREENING/ CONTACT TRACING FORM

Date/Time of Session: Date _____ Time _____

Full Name: First Name _____Last Name _____

Please check if you HAVE any of the following:
___ Fever (100.4 F or higher), or Chills? ___ Nausea/vomiting? ___ Diarrhea?
___ New cough? ___ Shortness of breath? ___ New sore throat?
___ New muscle aches? ___ New loss of smell or taste? ___ New headache?

In the last 14 days have you had a positive COVID-19 test? ____

In the last 14 days have you come in close contact with a confirmed or suspected COVID-19 case? ____

Parent/Guardian Signature: _____

Temperature Recorded by Rink Personnel: (Player)_____

Spectator #1 Name _____***Temp*** _____

Spectator #2 Name_____***Temp***_____