COVID-19 SCREENING / CONTACT TRACING FORM

Date/Time of Session: ___________ _______________
Date Time

Player Name: _______________________ ___________________________
First Name Last Name

If a parent / guardian is entering the building: ___________________________________
Parent Name(s)

Best Contact Number: _________________________________
Phone Number

Address: __________________________________

_________________ ______________ ________________
City State Zip Code

Please check if you <u>HAVE</u> 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 been in contact with a confirmed or suspected COVID-19 case? ___
Are you awaiting the results of a COVID-19 test? ____

If you answer "YES" to any of the above symptoms or questions you are not allowed in the rink.

I hereby affirm that to the best of my knowledge the above answers are true and accurate.

Parent/Guardian Signature: __________________________________