COVID-19 SCREENING/ CONTACT TRACING FORM

Date/Time of Session: Date _____ Time _____

Full Name: First Name _____ Last Name _____

Best Contact Number: Phone Number _____

Address: Street Address _____

Street Address Line 2 _____

City _____ State _____

Zip Code _____

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: _____