Steffi Nossen School of Dance COVID Check In Form

What’s is the dancer’s name?____________________________________________

Was the dancer’s temperature above 100.4F when you took their temperature today?   * Yes / No

Has the dancer had COVID-19 within the last 14 days?  * Yes / No

Has the dancer had any signs or symptoms of a fever in the past 24 hours such as chills, sweats, felt "feverish," or had a temperature that is elevated for you or 100.4F or greater?   * Yes / No

Has the dancer had any of the following symptoms? * Yes / No
• Fever or chills • Cough • Shortness of breath or difficulty breathing
• Fatigue • Atypical muscle pain or body aches • Headache • New loss of taste or smell
• Sore Throat • Congestion or runny nose • Nausea or vomiting • Diarrhea

Has the dancer traveled internationally, or domestically outside of the State of New York in the last 14 days to a state on NY’s COVID travel advisory list?  *Yes / No

Within the last 14 days, has the dancer been exposed to, or come into contact with, anyone you know: (a) who has COVID-19, or (b) who had symptoms consistent with COVID-19?   * Yes / No

Regardless of how you answer the questions provided in this survey, if the dancer has symptoms consistent with COVID-19 or feel they may be developing symptoms consistent with COVID-19, they cannot attend or participate in any Steffi Nossen activities and should contact a local healthcare professional.

*I HAVE READ THE ABOVE STATEMENT AND CERTIFY THAT THE ANSWERS ARE TRUE AND ACCURATE.

Name of adult completing this form _____________________________________________

Signature of adult completing this form ___________________________________________

Date ___________________________