

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? • *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* • * Yes / No

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 _____