# COVID-19 SELF CHECK

This completed form must be turned in before entering the competition.

NAME: _____ DATE OF COMPETITION: _____

DANCE STUDIO: _____

TEMPERATURE: _____

Anyone participating in or attending this competition will be required to have a temperature screening upon entering the building.

**In the past 14 days, do any of the following situations apply to anyone in your party?**

- Had a positive COVID test for active virus?
- Are awaiting a COVID-19 test result?
- Had close contact with an individual diagnosed with COVID-19?
- Have you traveled outside of the United States?

YES or NO (circle one)

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**In the past 48 hours, have you experienced any of the following symptoms?**

- cough
- fever or Chills
- fatigue
- shortness of breath or difficulty breathing
- sore throat
- headache
- new loss of taste or smell
- muscle or body aches
- nausea or vomiting
- diarrhea
- Unusual Rash

YES or NO (circle one)

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**If you have answered YES to any of these questions your access is <u>NOT APPROVED</u>. Thank you for helping us protect yourself and others during this time.**

SIGNATURE: _____ DATE: _____