ARCADE DANCE ARTS - COVID-19 - SCREENING FORM

NAME: DATE:

YES	NO	Are you or your dependent experiencing any symptoms of illness? Please circle any symptoms that apply: Cough --- Sore throat --- Shortness of breath --- Difficulty breathing Chest pain or pressure --- Fever --- Chills --- Muscle pains --- Loss of mobility --- Headache/migraine --- Conjunctivitis (pink eye) Rash on extremities --- New loss of taste or smell --- Upset stomach Vomiting --- Diarrhea
YES	NO	Have you or your dependent traveled or been in close contact with someone who has travelled either internationally or within the country to another province or territory in the last 14 days?
YES	NO	Do you believe that you or your dependent have been exposed to someone with a suspected and/or confirmed case of the Coronavirus/COVID-19?
YES	NO	Are you or your dependent awaiting the results of a Covid-19 test or have been diagnosed with a positive case of Covid-19 and not yet cleared as non contagious by health authorities?

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