

FEILE NOLLAIG - CONTACT TRACING AND HEALTH SCREENING FORM

Required for all participants, teachers and volunteers who will be entering the facility. Please have this completed and hand in at the check in desk at the entrance to the facility

PARENT / GUARDIAN NAME: _____

DANCER NAME: _____

EMAIL ADDRESS: _____

SIGNATURE: _____

I am (select one):

- Parent / Guardian (accompanying a dancer)
- Volunteer
- Teacher / TCRG

Health Screen

Do you currently have any of the following: YES NO

- Fever and/or Chills
- Cough or barking cough (croup)
- Difficulty Swallowing
- Shortness of breath
- Sore throat
- Decrease or loss of smell or taste
- Pink Eye
- Runny or stuffy / congested nose
- Headache
- Muscle aches
- Extreme tiredness
- Falling down often
- Digestive Issues (nausea/ vomiting, diarrhea, stomach pain)

Has a doctor, health care provider, or public health unit told you that you should currently be isolating (staying at home)?

- YES
- NO

In the last 14 days, have you been identified as a “close contact” of someone who currently has COVID-19?

- YES
- NO

If you answer “yes” to any of the above questions, you will not be permitted in the facility