Ed Burns Rink

Daily Health & Wellness Check

Please do not enter the facility if you answer "yes" to

ANY of the questions below.

1. Today or in the past 24 hours, has the participant or any household members had any of the following symptoms?

   A. Fever (temperature of 100.0°F or above), felt feverish, or had chills? ❑ Yes ❑ No
      - Current temperature: _____□ (taken by parent)

   B. Cough? ..... ❑ Yes ❑ No
   C. Sore throat? ..... ❑ Yes ❑ No
   D. Difficulty breathing? ..... ❑ Yes ❑ No
   E. Gastrointestinal symptoms (diarrhea, nausea, vomiting)? ..... ❑ Yes ❑ No
   F. Abdominal pain? ..... ❑ Yes ❑ No
   G. Unexplained Rash? ..... ❑ Yes ❑ No
   H. Fatigue? ..... ❑ Yes ❑ No
   I. Headache? ..... ❑ Yes ❑ No
   J. New loss of smell/taste? ..... ❑ Yes ❑ No
   K. New muscle aches? ..... ❑ Yes ❑ No
   L. Any other signs of illness? ..... ❑ Yes ❑ No

2. In the past 14 days, has the participant had close contact with a person known to be infected with the novel coronavirus (COVID-19)? ..... ❑ Yes ❑ No