COVID-19 QUESTIONNAIRE

Dancer Name: _____

Class: _____

	Please check one:	YES	NO
1.	Have you been diagnosed with known or suspected COVID-19 within the past 2 weeks? If so, when? _____		
2.	Have you spent time with (lived with or had close physical contact) someone who has been diagnosed with known or suspected COVID-19 within the past 2 weeks? If so, when? _____		
3.	Have you had a documented fever above 100.4° in the past 72 hours?		
4.	Do you have a persistent dry cough?		
5.	Have you experienced shortness of breath or any other breathing difficulties?		
6.	Have you experienced any chills?		
7.	Do you have a sore throat?		
8.	Have you recently experienced a loss of taste or smell?		
9.	Have you experienced any chest pain or body aches?		
10.	Have you had vomiting or diarrhea in the past 24 hours?		

If you answered yes to any of these above questions, you may not attend class today.

For our records, do you have asthma? Please circle **YES** or **NO**

Please list other concerns here: _____

Parent Signature: _____ Date: _____