



DYNAMIC ATHLETIC CENTER

Covid 19 Questionnaire

1. Has your student/s or any family member had any of the following respiratory symptoms?

- Cough
- Shortness of breath

OR at least TWO of these symptoms

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Repeated shaking with chills | <input type="checkbox"/> Muscle pain |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> New loss of test or smell | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Diarrhea | |

2. Have your student/s or any family member been exposed to a person or in a facility with recognized COVID 19 cases.

3. If YES to any of the questions above please do not bring your student to class. ?

A. Call to arrange a make-up once your athlete has been quarantined or in no longer showing any symptoms, OR has tested negative for COVID 19.

B. If your athlete has attended a class and tests positive at any time please notify our office asap so that we can be sure to notify any student within the class.

4. If NO come on in, be sure to wash or sanitize your hands before entering. Non-students please enter with mask on.

Submit this form to your instructor prior to your first class. Review & Repeat weekly before coming to class.

Note: only 1 Signed form needs to be given to your students instructor.

By signing I understand that it is my responsibility to Check my Athlete for all symptoms prior to coming to each class.

Parent or Guardian Signature: _____

Date: _____

Printed name: _____

Thanks so much , Welcome back.

Adana Harris