CORONAVIRUS DISEASE (COVID-19) VISITOR HEALTH SCREENING

Facility Visiting: Dearborn Ice Skating Center - DISC

Visitor's Name: _____ Time In: _____ am/pm

Phone #: ( )_____ Date: _____/_____/ 2021

Team/Group Name: _____

In the past 24 hours, have you experienced any of the following unusual symptoms:

Fever? (100.4°F or above)	☐ Yes	☐ No
Atypical Cough?	☐ Yes	☐ No
Atypical Shortness of Breath?	☐ Yes	☐ No
Runny nose or congestion?	☐ Yes	☐ No
Body aches and/or tiredness?	☐ Yes	☐ No
Vomiting and/or diarrhea?	☐ Yes	☐ No
New loss of smell or taste?	☐ Yes	☐ No
Conjunctivitis ('pink eye')?	☐ Yes	☐ No

In the past 14 days, have you:

Had close contact (within approximately six feet for a prolonged period of time or for multiple shorter periods of time) with an individual who has tested positive for COVD-19?	☐ Yes	☐ No

---------- FOR OFFICE USE ONLY ----------

If visitor answered "yes" to any of the above questions the visitor is NOT allowed access to the building.

If visitor answered "yes" to the above, was the visitor provided a CDC Sick with COVID-19 Fact Sheet? Yes / NO (circle one)

Staff Member contacted to inform them the visitor was not allowed into the building:
Date: _____ Time: _____ Spoke to: _____