



Please complete before entering the school.

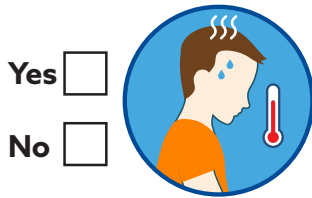
Dancer  
Name: \_\_\_\_\_

Parent/Guardian  
Signature: \_\_\_\_\_

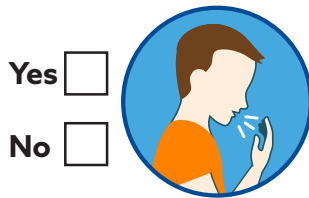
Date: \_\_\_\_\_

Time: \_\_\_\_\_

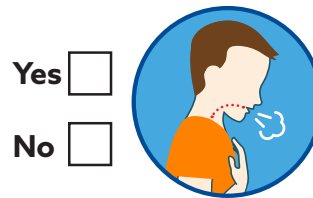
## Do you have any of the following:



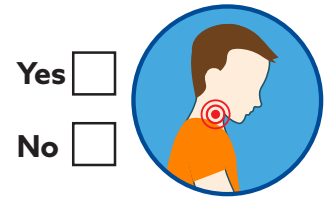
**Fever**



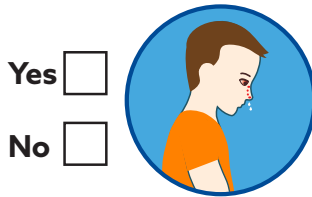
**Cough**



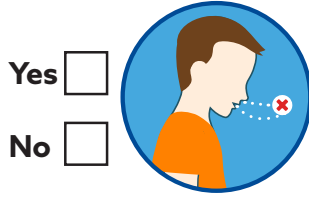
**Difficulty breathing**



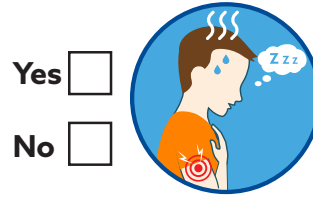
**Sore throat,  
trouble swallowing**



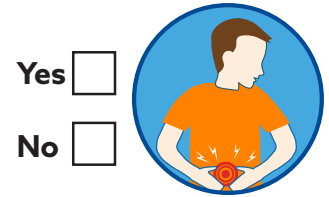
**Runny nose or  
red eyes**



**Loss of taste or  
smell**



**Not feeling well,  
tired or sore muscles**



**Nausea, vomiting,  
diarrhea**

Yes ☐ Have you been in close contact with someone who is  
No ☐ sick or has confirmed COVID-19 in the past 14 days?

Yes ☐ Have you returned from travel outside Canada in the  
No ☐ past 14 days?

**If you answered YES to any of these questions,  
go home & self-isolate right away. Call Telehealth  
or your health care provider, to find out if you  
need a test.**