GDC DANCER COVID-19 SCREENING FORM

THE SAFETY OF OUR DANCERS IS OUR OVERRIDING PRIORITY. AS THE CORONAVIRUS (COVID-19) PANDEMIC CONTINUES, WE ARE MONITORING THE SITUATION CLOSELY AND FOLLOWING CDC GUIDELINES. IN ORDER TO PREVENT THE SPREAD OF THE CORONAVIRUS AND REDUCE THE POTENTIAL RISK OF EXPOSURE TO OUR FACILITY, WE ARE ASKING ALL DANCERS TO COMPLETE AND SUBMIT THE COVID-19 QUESTIONNAIRE PRIOR TO ENTERING OUR DANCE SPACE. PLEASE DO NOT ENTER THE DANCE SPACE UNTIL YOUR RESPONSES HAVE BEEN REVIEWED AND YOUR ENTRY IS APPROVED.

PLEASE RESPOND TO EACH OF THE FOLLOWING QUESTIONS TRUTHFULLY AND TO THE BEST OF YOU ABILITY. YOUR PARTICIPATION IS IMPORTANT TO HELP US TAKE PRECAUTIONARY MEASURES TO PROTECT OUR DANCERS, FAMILIES AND FACULTY MEMBERS.

EMPLOYEE USE ONLY -
DATE:
EMPLOYEE INITIAL:

PLEASE FILL OUR THE FOLLOWING INFORMATION -

DANCER NAME	
PARENT NAME	
PARENT PHONE #	

1. ARE YOU CURRENTLY EXPERIENCING, OR HAVE YOU EXPERIENCED IN THE PAST 14 DAYS, ANY OF THE FOLLOWING SYMPTOMS? (PLEASE TAKE YOUR TEMPERATURE BEFORE YOU ANSWER THIS QUESTION.)

FEVER (100.4 OR GREATER)	YES	NO
COUGH	YES	NO
SHORTNESS OF BREATH OR DIFFICULTY BREATHING	YES	NO
SORE THROAT	YES	NO
NEW LOSS OF TASTE OR SMELL	YES	NO
CHILLS	YES	NO
HEAD OR MUSCLE ACHE	YES	NO
NAUSEA,DIARRHEA, VOMITING	YES	NO

2. IN THE PAST 14 DAYS, HAVE YOU BEEN IN CLOSE PROXIMITY TO ANYONE WHO WAS EXPERIENCING ANY OF THE ABOVE SYMPTOMS OR HAS EXPERIENCED ANY OF THE ABOVE SYMPTOMS SINCE YOUR CONTACT?

   YES ☐ NO☐

3. IN THE PAST 14 DAYS, HAVE YOU BEEN IN CLOSE PROXIMITY TO ANYONE WHO HAS TESTED POSITIVE FOR COVID-19?

   YES ☐ NO☐

4. HAVE YOU BEEN TESTED FOR COVID-19 AND ARE WAITING TO RECEIVE TEST RESULTS?

   YES ☐ NO☐

5. HAVE YOU HAVE TESTED POSITIVE FOR COVID-19, OR ARE YOU PRESUMPTIVELY POSITIVE FOR COVID-19 BASED ON YOUR HEALTH CARE PROVIDER'S ASSESSMENT OR YOUR SYMPTOMS?

   YES ☐ NO☐

   NOTE: IF YOU HAVE TESTED POSITIVE FOR COVID-19 OR HAVE BEEN PRESUMPTIVELY POSITIVE FOR COVID-19 BASED ON YOUR HEALTH CARE PROVIDER'S ASSESSMENT OR YOUR SYMPTOMS, PLEASE CONTACT YOUR MANAGER OR HUMAN RESOURCES REPRESENTATIVE WHEN: (1) YOU HAVE HAD NO FEVER FOR AT LEAST 72 HOURS (3 FULL DAYS), WITHOUT THE USE OF FEVER-REDUCING MEDICATIONS; (2) YOUR OTHER SYMPTOMS HAVE IMPROVED; AND AT LEAST 7 DAYS HAVE ELAPSED SINCE YOUR SYMPTOMS FIRST APPEARED.

6. IN THE PAST 14 DAYS, HAVE YOU BEEN ON A COMMERCIAL FLIGHT OR TRAVELED OUTSIDE OF THE UNITED STATES?

   YES ☐ NO ☐

7. IN THE PAST 14 DAYS, HAVE YOU BEEN IN CLOSE PROXIMITY TO ANYONE WHO HAS BEEN ON A COMMERCIAL FLIGHT OR TRAVELED OUTSIDE OF THE UNITED STATES?

   YES ☐ NO ☐

8. IS THERE ANY REASON WHY YOU FEEL YOU ARE AT HIGHER RISK OF CONTRACTING COVID-19 OR EXPERIENCING COMPLICATIONS FROM COVID-19 BY ENTERING THE FACILITY? IF "YES", PLEASE PROVIDE A BRIEF EXPLANATION.

   YES ☐ NO☐

   EXPLANATION:

   _____