

Date: _____

Full Name *

First Name	Last Name

Best Contact Number *

Phone

Address

Street Address

Street Address Line 2

City	State / Province

Zip

Please Check the box if you HAVE any of the following:

- Fever (100.4 F or higher), or feeling feverish?
- Chills?
- A new cough?
- Shortness of breath?
- A new sore throat?
- New muscle aches?
- New headache?
- New loss of smell or taste?

Temperature

Recorded by rink

Personnel _____