Malone Civic Center
64 State Street
Malone, NY 12953

COVID-19 SCREENING/ CONTACT TRACING FORM

Date/Time of Session: _____ _____
Date Time

Full Name: (1)_____(2)_____(3)_____ _____
First Name Last Name

Best Contact Number: _____
Phone Number

Address: _____
Street Address

_____
Street Address Line 2

_____ _____
City State

_____
Zip Code

Please check if you <u>HAVE</u> any of the following:

___ Fever (100.4 F or higher), or Chills? ___ Nausea/vomiting? ___ Diarrhea?

___ New cough? ___ Shortness of breath? ___ New sore throat?

___ New muscle aches? ___ New loss of smell or taste? ___ New headache?

In the last 14 days have you had a positive COVID-19 test? ____
In the last 14 days have you come in close contact with a confirmed or suspected COVID-19 case? ____

Parent/Guardian Signature: _____

Temperature Recorded by Rink Personnel: (1)_____(2)_____(3)_____