TURNING POINTE DANCE CENTRE/TRILOGY DANCE COMPANY

INTAKE FORM

Have you, your child(ren), or any persons in your household, experienced any of the following symptoms in the last 14 days, including but not limited to, fever, dry cough, fatigue, shortness of breath, difficulty of breathing, loss of taste/smell?

YES _____ NO _____

Have you or your child(ren) been in contact with anyone who has exhibited any of the above symptoms in the last 14 days?

YES _____ NO _____

Have you, your child(ren), or anyone you have been in contact with, received a positive COVID-19 test in the last 14 days?

YES _____ NO _____

Have you or your child(ren) traveled in the last 21 days?

YES _____ NO _____

If yes, where to and by what form of transportation ?

_____

_____ _____ _____

PARENT NAME PARENT SIGNATURE DATE

CHILD(REN) NAMES:

_____ _____

_____ _____

_____ _____

_____ _____