

### DAILY COVID-19 DAILY CLASS CHECK-IN

Students Name: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Instructor(s) : \_\_\_\_\_ POD# \_\_\_\_\_

You must be able to answer NO to every question to be allowed in class:

1. Have you had contact with ANYONE CONFIRMED COVID-19 POSITIVE in the last 14 days? YES \_\_\_ NO \_\_\_
2. Have you traveled outside of the Country in the last 14 days? YES \_\_\_ NO \_\_\_
3. Have you traveled to a State not contingent to (bordering) NYS in the last 14 days? YES \_\_\_ NO \_\_\_ Please list State \_\_\_\_\_
4. Have you trained at any other martial arts schools, clubs, or personal training spaces involving direct contact with others in the last 14 days? YES \_\_\_ NO \_\_\_
5. Have you had any of the following symptoms in the last 14 days?
  - Fever? YES \_\_\_ NO \_\_\_
  - Cough? YES \_\_\_ NO \_\_\_
  - Shortness of breath? YES \_\_\_ NO \_\_\_
  - Loss of taste or smell? YES \_\_\_ NO \_\_\_

Temperature: \_\_\_\_\_

Student Signature \_\_\_\_\_

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

