

AYHA Contact Tracing & Health Screening

Have had any of the following in the last 48 hours?

- Cough YES / NO
- Shortness of breath or difficulty breathing YES / NO
- Fever YES / NO
- Chills YES / NO
- Muscle pain YES / NO
- Headache YES / NO
- Sore throat YES/ NO
- New loss of taste or smell YES / NO
- Temperature of 100.3 or more YES /NO
- Have you travelled to any state(s) on the NY State restricted list in the last 14 days?
YES / NO

If the answer is YES to any of these questions, DO NOT ENTER.

Anyone entering the COOL Insuring Arena MUST have a face covering on.

Player/Staff Name:	
Player/Staff Cell Phone:	
Parent/Guardian Cell Phone:	
Player/Staff Address:	
Street:	
City:	
State:	
Zip:	
Group Skating With:	
On Ice Time:	
Date:	