Team ______________________________

Facility ______________

Date/Time ______________

Question	Name	Name	Name	Name	Name	Name
	☐ Ref ☐ Timekeeper ☐ Scorekeeper ☐ ____________	☐ Ref ☐ Timekeeper ☐ Scorekeeper ☐ ____________	☐ Ref ☐ Timekeeper ☐ Scorekeeper ☐ ____________	☐ Ref ☐ Timekeeper ☐ Scorekeeper ☐ ____________	☐ Ref ☐ Timekeeper ☐ Scorekeeper ☐ ____________	☐ Ref ☐ Timekeeper ☐ Scorekeeper ☐ ____________
Have you experienced a fever of 38.8˚C or greater in the past 10 days?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you received a positive result from a COVID-19 test within the past 14 days?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you been in contact with anyone while they had COVID-19 or symptoms of COVID-19 in the past 14 days?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
In the past 14 days, have you, or someone you have been in contact with, traveled outside your state/province/country or to an area with restrictions due to COVID-19?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you experienced any of the following symptoms within the past 14 days? Check all that apply.	☐ Cough ☐ Loss of smell or taste ☐ Runny nose ☐ Shortness of breath ☐ Sore throat ☐ None	☐ Cough ☐ Loss of smell or taste ☐ Runny nose ☐ Shortness of breath ☐ Sore throat ☐ None	☐ Cough ☐ Loss of smell or taste ☐ Runny nose ☐ Shortness of breath ☐ Sore throat ☐ None	☐ Cough ☐ Loss of smell or taste ☐ Runny nose ☐ Shortness of breath ☐ Sore throat ☐ None	☐ Cough ☐ Loss of smell or taste ☐ Runny nose ☐ Shortness of breath ☐ Sore throat ☐ None	☐ Cough ☐ Loss of smell or taste ☐ Runny nose ☐ Shortness of breath ☐ Sore throat ☐ None

Please photograph and send to **safety@vfiha.com** at the conclusion of your ice time.