Wellness Declaration Form

Full Name:

Date:

Current Body Temperature (Â°C):

In the past 14 days, have you experienced any of the following symptoms? (Check all that apply)

- [ ] Fever
- [ ] Cough
- [ ] Shortness of Breath
- [ ] Sore Throat
- [ ] None of the above

Have you been in contact with anyone diagnosed with a communicable disease in the past 14 days?

- ( ) Yes
- ( ) No

Signature:

Submit