

COVID-19 Self Health Declaration Form

Purpose of this form:

Keeping in mind the health and safety of our community, a declaration of illness is now a prerequisite before booking a slot at our facility. Kindly confirm that the information you share with us is complete and true to the best of your knowledge. If you notice any symptoms related to COVID-19, please make sure to seek medical attention at the earliest.

First Name: _____ Last Name: _____

Email: _____ Membership ID (if any): _____

What is your current vaccination status?

☐

Partially vaccinated

☐

Not vaccinated

☐

Fully vaccinated

Have you returned from another country or state in the last 14 days?

☐

Yes

☐

No

Have you been in contact with a person who has returned from another country or state in the last 14 days?

☐

Yes

☐

No

Have you been in contact with a person who was later diagnosed with COVID-19 in the last 14 days?

☐

Yes

☐

No

Have you experienced any cold or flu-like symptoms in the last 14 days (to include fever, cough, sore throat, respiratory illness, difficulty breathing)?

☐

Yes

☐

No

☐ I acknowledge that the information I've given is accurate and complete.

Date: _____ / _____ / _____