TV Show COVID-19 Audience Health Declaration

Personal Information

Full Name

_____

Contact Number

_____

Email Address

_____

Date of Attendance

_____

Health Screening Questions

1. Have you had any of the following symptoms in the last 14 days? (Fever, cough, sore throat, shortness of breath, loss of taste or smell, etc.)

_____

2. Have you tested positive for COVID-19 in the last 14 days?

_____

3. Have you had close contact with a confirmed COVID-19 case in the last 14 days?

_____

4. Have you traveled internationally in the last 14 days?

_____

I declare that the information provided above is true and accurate to the best of my knowledge. I understand that I may be denied entry if any of the above information indicates a risk for COVID-19.

Signature

_____

Date

_____