Culinary Food Tour Health Declaration Form

Full Name

Date

Contact Number

Email Address

Do you have any food allergies?

Dietary Restrictions

Medical Conditions

Have you experienced any fever, cough, or respiratory symptoms in the past 14 days?

Have you been in close contact with anyone confirmed to have a contagious illness in the past 14 days?

☐ I confirm that the above information is true and complete.

Signature