Infectious Disease Exposure History Form

Full Name

Date of Birth

Contact Number

Email

Address

Have you been exposed to any known infectious diseases in the past 14 days?

If yes, specify the disease(s) and exposure date(s)

Are you currently experiencing any of the following symptoms? (Check all that apply)

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

Additional Information

Date

Signature