COVID-19 Health Self-Assessment

Personal Information

Full Name

Date

Email Address

Phone Number

Health Screening Questions

1. Are you experiencing any of the following symptoms: fever, cough, shortness of breath, sore throat, or loss of taste/smell?

Yes

No

2. Have you tested positive for COVID-19 in the past 10 days?

Yes

No

3. Are you waiting for the results of a COVID-19 test?

Yes

No

4. Have you had close contact with anyone who has tested positive for COVID-19 within the past 14 days?

Yes

No

5. Have you been advised to self-isolate or quarantine by a health authority?

Yes

No

Declaration

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I confirm that the above information is accurate and complete.