COVID-19 Wellness Declaration

Full Name

Room Number

Date

Health Screening

Have you experienced any of the following symptoms in the past 14 days?

- [ ] Fever
- [ ] Cough
- [ ] Shortness of breath
- [ ] Loss of taste or smell

Have you tested positive for COVID-19 in the past 14 days?

- ◯ Yes
- ◯ No

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

- ◯ Yes
- ◯ No

Other Comments

Signature