Spa COVID-19 Health Declaration Form

Full Name

Date

Phone Number

Email Address

Are you currently experiencing any of the following symptoms?

☐ Fever ☐ Cough ☐ Shortness of breath ☐ None of the above

Have you been in contact with anyone confirmed or suspected to have COVID-19 in the last 14 days?

Have you recently traveled internationally in the last 14 days?

Additional Comments