Hotel Health Declaration Consent Form

Full Name

Room Number

Contact Number

Date

Health Status

Have you experienced any of the following symptoms in the past 14 days? (Fever, cough, sore throat, breathing difficulty, loss of taste/smell)

Have you been diagnosed with any infectious disease in the last 14 days?

Have you had close contact with a confirmed or suspected infectious disease case in the past 14 days?

If you answered "Yes" to any of the above, please provide further details

Consent

I confirm that the information provided above is accurate and complete to the best of my knowledge. I consent to the processing of this information for health and safety purposes during my hotel stay.