COVID-19 Entry Health Waiver Form

Personal Information

Full Name

Date

Phone

Email

Health Screening Questions

☐ Have you had a fever or chills in the last 14 days? ☐ Have you had a new or worsening cough?

☐ Have you experienced shortness of breath? ☐ Have you had a sore throat? ☐ None of the above

☐ Have you been in close contact with someone diagnosed with COVID-19 in the past 14 days?

☐ No known contact

Travel History

Have you traveled outside your country or region in the past 14 days? If yes, where?

I declare that the information I have provided is true and accurate to the best of my knowledge. I understand that providing false or misleading information may have health and safety implications.

Signature:

Date: