

COVID-19 Questionnaire

INSTRUCTIONS : ALL CLIENTS ENTERING HERITAGE SPA MUST BE ASKED THE FOLLOWING QUESTIONS BELOW. HERITAGE SPA WILL MAINTAIN THIS RECORD FOR 14 DAYS FROM COMPLETION OF THIS FORM AND HAVE THIS FORM AVAILABLE UPON REQUEST FROM THE PUBLIC HEALTH DEPARTMENT.

By checking this box, I pledge to provide only correct and truthful information when completing this screening.

01

Do you have any of the following respiratory symptoms ?

- New or worsening cough ? Yes No

- New or worsening shortness of breath ? Yes No

02

Have you had a temperature 100,4°F (38°C) or greater within the last 14 days

Yes No

03

Are you feeling feverish ?

Yes No

04

Are you having chills ?

Yes No

05

Have you been in a facility or home with confirmed COVID-19 by lab test within the last 14 days ?

Yes No

06

Have you been with persons with confirmed COVID-19 by lab test within the last 14 days ?

Yes No

* The person answering YES to any of the above questions is responsible for following-up with their primary care physician if needed.

Client's Full Name :

Email : Tél :

Hôtel/Riad :

Passport Number :

Date :