1. ***Do you/ they have a fever or have you/they felt hot or feverish recently? Yes or No***

2. ***Are you/they having shortness of breath or other difficulties breathing? Yes or No***

3. ***Do you/ they have a cough? Yes or No***

4. ***Any other flu- like symptoms, such as gastrointestinal upset, headache or fatigue? Yes or No***

5. ***Have you/ they experienced recent loss of taste or smell? Yes or No***

6. ***Are you/ they in contact with any confirmed COVID-19 positive patients? Yes or No***

7. ***Is your/ their age over 60? Yes or No***

8. ***Do you/ they have heart disease, lung disease, kidney disease, Diabetes or any auto immune disorders? Yes or No***

9. ***Have you/they traveled in the past 14days to any regions affected by COVID-19?***

   Yes or No

I confirm that I am not presenting any of the following symptoms of Covid-19.

Signature: _____ Date _____