Date: _____

Full Name *

First Name | Last Name

Best Contact Number *

Phone

Address

Street Address

Street Address Line 2

City | State / Province

Zip

Please Check the box if you HAVE any of the following:

- ☐ Fever (100.4 F or higher), or feeling feverish?
- ☐ Chills?
- ☐ A new cough?
- ☐ Shortness of breath?
- ☐ A new sore throat?
- ☐ New muscle aches?
- ☐ New headache?
- ☐ New loss of smell or taste?

Signature _____ **Date** _____