COVID-19 Health Screening Form

Please read and answer each question below. All responses must be true and should be circled as either "yes" or "no". Please do not skip any questions.

1. Have you experienced any of the following symptoms in the past 48 hours: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea?

   YES NO

2. Within the past 14 days, have you been in close physical contact with a person who is known to have laboratory-confirmed COVID-19 or with anyone who has any symptoms consistent with COVID-19?

   YES NO

3. In the last 14 days, have you traveled from another state or country for which New York State requires a mandated self-quarantine period?

   YES NO

4. Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?

   YES NO

5. Are you currently waiting on the results of a COVID-19 test?

   YES NO

If the answer to any of these questions is 'yes', you may be denied services until a physician's note is provided. By signing this form, you are indicating that you agree to abide by Spa Euforia's policy.

Name: _____ Address: _____

Phone: _____ Date: _____