



ESTHETICA

COVID-19 QUESTIONNAIRE

- 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

Client's Full Name :

Email : Tél :

Hôtel/Riad :

Passport Number :

Date :