Health Validation Form

Name: _____ Date: _____
(Please Print)

Contact Phone: ( ) _____-_____

Please indicate any of the following symptoms:

- **Cough** **YES** **NO**
- **Short of breath** **YES** **NO**
- **Fever** **YES** **NO**
- **Chills** **YES** **NO**
- **Muscle Pain** **YES** **NO**
- **Sore Throat** **YES** **NO**
- **New loss of taste or smell** **YES** **NO**
- **Nausea** **YES** **NO**
- **Vomiting** **YES** **NO**
- **Diarrhea** **YES** **NO**

1. **I have not been around anyone with any of the listed symptoms or diagnosis of COVID-19. Initial _____**
2. **No one in my household has been sick. Initial _____**
3. **I have not traveled by air or traveled out of state. Initial _____**
4. **I have adhered to our state's guidelines regarding COVID-19. Initial. _____**

My signature indicates that I have completed this to the best of my ability. We understand that arriving to Park Shore healthy is vital for all.

Signature: _____ Date: _____
(Parent of Guardian if under 18 years of age)