



# Health Attestation

Full Name \_\_\_\_\_

If Minor Parent/Guardian Name: \_\_\_\_\_

Phone Number \_\_\_\_\_

Email Address \_\_\_\_\_

Please review the following statements:

1. In the last 10 days, have you tested positive on a COVID-19 rapid antigen test, a self-testing kit or have been tested and are awaiting results?
2. Have you been directed by the health department, a physician or other healthcare professional to self-isolate for a period of time including today?
3. Do you have any of the following new or worsening, signs or symptoms:
  - Fever or chills
  - Cough, croup (squeaky or whistling nose when breathing), severe difficulty breathing or shortness of breath
  - Sore throat, hoarse voice or difficulty swallowing
  - Stuffy, congested or runny nose
  - Severe chest pains
  - Loss of consciousness
  - Feeling confused or unsure of where you are
  - Not feeling well
  - Falling down often
  - Fatigue\* that is unusual, lack of energy or sluggishness
  - Muscle aches or joint pain\* that is unusual or long lasting
  - Headache\* that is unusual or long lasting
  - Pink eye
  - Decrease in or loss of smell or taste
  - Lack of appetite
  - Digestive issues (nausea/vomiting, diarrhea or stomach pain)

\*If you received a COVID-19 vaccination in the last 48 hours and are experiencing mild headache, mild muscle ache, mild joint pain, and/or mild fatigue that began after vaccination, and have no other symptoms, select "NO" for question 3.

4. In the last 14 days, have you had close contact\* with someone who has or is suspected of having COVID-19 (including exhibiting any of the listed symptoms\*\* and/or awaiting test results)? If you are fully vaccinated (received the full series of a USA-approved COVID-19 vaccine at least 14 days ago) and have not been advised to self-isolate by the health department, you may select 'NO' to Question 4.

\*Close contact means being less than 2 metres or 6 feet away in the same area for at least 10 minutes, living in the same home or physical contact such as shaking hands, hugging, being coughed on, sneezed on, spit on or receiving an exposure notification.

\*\*If the individual experiencing symptoms was vaccinated in the last 48 hours and is experiencing mild headache, mild muscle or joint ache, and/or mild fatigue and the symptoms started after vaccination, then you can answer "NO" to Question 4.

5. Have you travelled outside of the United States in the past 14 days and been advised to quarantine in accordance with the United States quarantine requirements?

**Did you answer Yes to ANY of the above questions?**

Yes

No

I hereby certify the above information is accurate to the best of my knowledge:

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Signature (Parent or Guardian Signature if Minor)