HEALTH QUESTIONNAIRE FORM

DATE: __________

NAME: ______________________________

DEPENDENT'S NAME: ___________________________
(MEMBER'S GUARDIAN USE ONLY)

- Within the last 48 hours, have you and/or your dependent experienced any symptoms of cough, runny nose, diarrhea, labored breathing due to upper respiratory infections?
  - ❏ Yes
  - ❏ No
- Have you and/or your dependent had a fever in the last 24 to 48 hours?
  - ❏ Yes
  - ❏ No
- Have you and/or your dependent traveled within the United States in the last 30 days?
  - ❏ Yes, Where? _____________________
  - ❏ No
- Have you and/or your dependent traveled outside of the United States in the last 30 days?
  - ❏ Yes, Where? ______________________
  - ❏ No

By completing this form, you acknowledge that you have answered the above questions to the best of your ability with truth. You agree & understand, that should you experience any of the above symptoms, you will <u>NOT</u> participate in any classes or private sessions until your symptoms have resolved and are fever free for over 24 hours.

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[Signature]