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**Personal Care, Inc. Health Declaration**

To assist us in protecting the health and safety of all Personal Care clients and employees please answer the following questions:

1. In the past 30 days, have you or someone in your household traveled out of the country?  
     
   ꙱ YES ꙱ NO   
   1a. If YES, where have you traveled?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. In the past 14 days, have you or anyone in your household had contact with a suspected case of coronavirus, or a person under monitoring for coronavirus?   
     
   ꙱ YES ꙱ NO
3. In the past 14 days, have you had a fever, cough, or difficulty breathing?  
     
   ꙱ YES ꙱ NO  
   If YES, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you answer “YES” to any of the above questions, we may ask you to avoid contact with Personal Care client and employees and seek any necessary medical attention.

* I have been given a copy of CDC guidelines for COVID-19 and will follow these guidelines.
* I will report any changes in my health condition to Personal Care
* I certify that the above declaration is true and correct and that any dishonest answers may have serious public health implications.

Your Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_