BEAUTY BY Stella

Health declaration form for COVID-19

Name:	
Email address:	
Contact details:	Mobile:

	Description	Yes	No	Info
1	Have you, or anyone whom you share a residence with, been in contact with any person suffering or suspected to be suffering from COVID-19 in the last 14 days?	☐	☐	
2	Do you have any fever or respiratory symptoms (e.g. cough, runny nose, sore throat, loss of smell and taste or breathing difficulty, which are not caused by seasonal allergies such as hay-fever? Would you consider yourself as high risk that may increase your vulnerability to COVID-19. High blood pressure – Diabetes – Heart disease or pregnant?	☐	☐	
3	Have you visited any countries outside of the UK in the last 14 days? (please state where) or a UK Holiday if so where and when?	☐	☐	

If your answer is "YES" to any of the above questions, we regret to inform you that you are not to come to your appointment.

DECLARATION

I declare the above responses to be true and accurate to the best of my knowledge. In filling out this form digitally, you are agreeing that your electronic signature (typing your name) is the legally binding equivalent of your handwritten signature.

Signature: Date:

CONSENT

I consent to the above information being processed for the purpose of COVID-19 screening and subsequent contact tracing where required. All records to be stored in accordance with GDPR. If you would like to change or delete any of the information collected and stored by Beauty by Stella, please contact 07956 316 577.

Signature:

Received by: Date: