Covid-19 Health Declaration Form

Personal Information

Full Name:

Date of Birth:

Contact Number:

Residential Address:

Health Status

Do you currently have any of the following symptoms? (check all that apply)

- [ ] Fever
- [ ] Cough
- [ ] Shortness of breath
- [ ] Sore throat
- [ ] Loss of taste/smell
- [ ] None

Quarantine and Isolation History

Have you been in quarantine or isolation in the last 14 days?

( ) Yes ( ) No

If yes, please specify dates and location:

Exposure History

Have you been in close contact with anyone confirmed or suspected to have Covid-19 in the past 14 days?

( ) Yes ( ) No

Declaration

I declare that the information provided above is accurate and complete to the best of my knowledge. I understand that providing false information may have serious public health consequences.

Signature:

Date:

Submit