# COVID-19 Health Risk Assessment Form Sample

This **COVID-19 health risk assessment form sample** is designed to help identify potential exposure and symptoms related to the virus. It ensures accurate screening to protect public health and maintain safety in various environments. Utilizing this form supports effective decision-making and timely intervention.

Personal Information

Full Name:

Date of Birth:

Contact Number:

Email Address:

Exposure & Symptom Screening

**In the past 14 days, have you:**

- ☐ Been in close contact with anyone confirmed or suspected to have COVID-19?
- ☐ Traveled internationally or to an area with high rates of COVID-19?

**Are you currently experiencing any of the following symptoms?**

- ☐ Fever or chills
- ☐ Cough
- ☐ Shortness of breath or difficulty breathing
- ☐ Loss of taste or smell
- ☐ Sore throat
- ☐ Muscle or body aches
- ☐ Other (please specify):

Vaccination Status

Have you received a COVID-19 vaccine?

--Select an option--

Declaration & Signature

- ☐ I hereby declare the information provided is true and correct to the best of my knowledge.

Signature:

Date:

Submit Assessment