COVID Health Declaration Form

Full Name:

Date of Birth: YYYY-MM-DD

Contact Number:

Address:

Email:

Health Information (Past 14 Days)

Fever:
Yes No

Cough:
Yes No

Shortness of Breath:
Yes No

Sore Throat:
Yes No

Loss of Taste or Smell:
Yes No

Other Symptoms:

Exposure & Travel History (Past 14 Days)

Contact with COVID-19 Positive Person:
Yes No

Recent International Travel:
Yes No

If yes, please specify countries:

Quarantine Status:
Yes No

Signature:

_____
Date:

_____