Health Declaration Form

Full Name:

Date of Birth:

Contact Number:

Have you experienced any of the following symptoms in the past 14 days?

- [ ] Fever
- [ ] Cough
- [ ] Sore Throat
- [ ] Shortness of Breath
- [ ] None of the above

Have you had close contact with a confirmed COVID-19 case in the past 14 days?

- ( ) Yes
- ( ) No

Current Address:

- [ ] I hereby declare that the information provided is true and correct.

Submit