

# Personal Health Declaration Form

Full Name:

Date of Birth:

Address:

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

- ☐ Fever
- ☐ Cough
- ☐ Shortness of Breath
- ☐ None of the above

Do you have any pre-existing medical conditions?

Declaration:

- ☐ I hereby declare that the information provided above is true and accurate.

Submit