

Health Status Confirmation Form

Full Name:

Date of Birth:

Contact Number:

Do you have any symptoms such as fever, cough, or difficulty breathing?

☐ Yes ☐ No

Have you been in contact with a confirmed COVID-19 case in the last 14 days?

☐ Yes ☐ No

Additional Comments:

☐ I hereby confirm the above information is true and correct to the best of my knowledge.

Submit