

# Health Declaration Form

Full Name:

Date of Birth:

Gender:

Contact Number:

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

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

Have you traveled internationally in the last 14 days?

☐ I hereby declare that the information given is true and correct.

Submit