Individual Health Declaration

Full Name:

Date of Birth:

Address:

Contact Number:

1. Are you experiencing any of the following symptoms? (Check all that apply):

- [ ] Fever
- [ ] Cough
- [ ] Difficulty Breathing
- [ ] None of the Above

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

- ( ) Yes
- ( ) No

Other Relevant Information:

Date:

Signature:

Submit