

(SPECIALTY SOCIETY /BOARD)

HEALTH DECLARATION CHECKLIST

IMPORTANT REMINDER: *The information gathered on this form will be used only to determine whether you may be infected with COVID-19. The information on this form is strictly confidential.*

FILL OUT ENTRIES IN BOLD LETTERS

PERSONAL DATA:

Name: _____

Last name First name Middle name

Sex: () Male Age: ____ Nationality: _____ Civil status: _____
() Female

Contact Address: _____

(House No. and street) Barangay (Town/district)

(City/province) (Country) (Postal/Zip code)

Telephone No./Mobile No.: _____ Email address: _____

Please check if you have any of the following at present or during the past 14 days:

- | | | |
|-----------------------------|-----------------------------|----------------------|
| () fever >37.5 C | () sore throat | () diarrhea |
| () cough | () headache | () body aches |
| () difficulty of breathing | () loss of smell or taste. | () colds/runny nose |
| () body weakness | () fatigue | () nausea/vomiting |

Please enumerate, if any, cities in the Philippines you have lived, worked, transited in the past 14 days

Please enumerate, if any, foreign countries you have lived, worked, transited in the past 14 days

Please check the appropriate box:

- | | | |
|--|---------|--------|
| In the last 14 days, have you been in close contact or exposed to any person suspected of COVIDS-19? | () Yes | () No |
| Were you confined in a hospital/health care facility during the past 14 days? | () Yes | () No |
| Have you been diagnosed to have pneumonia in the past 14 days? | () Yes | () No |
| Did you visit any health facility, hospital or clinic in the past 14 days? | () Yes | () No |
| Do you have any household member/s or close contact/s who | () Yes | () No |

are currently having fever, cough, or any respiratory problems?

In the last 14 days, have you been in contact with a COVID-19 confirmed person? (.) Yes (.) No

When did this contact or person tested positive for RT-PCR? _____

Have you undergone any test for SARS-COV2 for the past 14 days? () Yes () No

Test Type:

- RT-PCR Rapid serologic antibody test
 Gene expert Rapid Antigen Test
 Others,, specify _____

Result:

- positive Negative Reactive Non-reactive
 sample unfit for testing Pending

Where was the test done? _____ Date of release: _____

DO NOT WRITE BELOW THIS LINE)

TO BE ACCOMPLISHED BY (SPECIALTY SOCIETY/BOARD) PROCTOR:

Result of RT-PCR required by (Specialty Society/Board): [.] Positive [.] Negative

Date of release: _____

Note/observations, if any: _____