COVID-19 Health & Attendance Declaration Form

Personal Information

Full Name

Date

Email

Phone Number

Location / Department

Health Screening

In the past 14 days, have you experienced any of the following symptoms?

- [ ] Fever or chills
- [ ] Cough
- [ ] Shortness of breath
- [ ] Loss of taste or smell
- [ ] None of the above

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

- ○ Yes
- ○ No

Have you tested positive for COVID-19 in the past 14 days?

- ○ Yes
- ○ No

- [ ] I declare that the information provided above is true and accurate to the best of my knowledge.