

Humanitarian Aid Worker Health Declaration

Full Name

Position/Role

Organization

Date

Have you experienced any of the following symptoms in the past 14 days? (Fever, cough, shortness of breath, sore throat, loss of taste/smell, etc.)

If yes, please specify

Have you been in close contact with a confirmed or suspected case of infectious disease in the past 14 days?

If yes, please specify

Do you have any chronic medical conditions (e.g., diabetes, hypertension, asthma, etc.)?

If yes, please specify

Are you currently taking any medications?

If yes, please specify

Are your vaccinations up to date?

Additional Remarks