

# Covid-19 Health Status Self-Declaration

## Personal Information

Full Name

Contact Number

Date

Location/Address

## Health Declaration

I declare that I am not currently experiencing cough, fever, sore throat, or difficulty breathing.

I have not been in close contact with a confirmed Covid-19 patient in the past 14 days.

I have not tested positive for Covid-19 in the last 14 days.

I have not traveled internationally in the past 14 days.

## Vaccination Status

Fully Vaccinated

Partially Vaccinated

Not Vaccinated

## Declaration

I confirm that the information furnished above is true to my knowledge.

Signature

(Type your name)

## **Important Notes:**

- This declaration must be filled out honestly and accurately.
- False information may have legal or disciplinary consequences.
- The data provided is confidential and intended for health & safety purposes only.
- If you develop symptoms or test positive after submitting this form, notify the relevant authority immediately.