

**Health Attestation Forms**

**Health Attestation Form**

**Personal Information:**

* **Full Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Contact Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Email Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Declaration:**

1. **Symptom Check** (Please check any that apply in the past 14 days):

	* Fever
	* Cough
	* Sore throat
	* Shortness of breath
	* Loss of taste or smell
	* None of the above
2. **Recent Health History:**
	* Have you tested positive for any infectious diseases such as COVID-19 in the past 14 days?

		+ Yes
		+ No
	* If yes, provide the date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. **Vaccination Status:**
	* Are you vaccinated against COVID-19?

		+ Yes
		+ No
	* If yes, please provide the date of your last vaccination dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	* Type of vaccine administered: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. **Travel History:**
	* Have you traveled internationally or to a community spread area in the past 14 days?

		+ Yes
		+ No
	* If yes, specify locations visited and dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. **Exposure Risk:**
	* Have you been in close contact with anyone who has been diagnosed with an infectious disease such as COVID-19?

		+ Yes
		+ No

**Certification and Signature:**

I certify that the information provided above is true and accurate to the best of my knowledge. I understand that providing false information may have serious consequences.

* **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_