Capitol University Medical Center
HEALTH DECLARATION FORM

- This form is for the safety and protection of everyone in this epidemic time. This is to screen all INDIVIDUALS entering the hospital premises. The information herein will be used in accordance to law and to contact you in such cases of any transmission of communicable disease. This form shall be kept with confidentiality and with privacy. Kindly fill out completely and accurately.

Date:_____ TEMP: _____ DESTINATION: _____

SURNAME	FIRST NAME	MIDDLE NAME	SUFFIXES

CURRENT ADDRESS				
HOUSE#	STREET	ZONE/SUBDIVISION	BARANGGAY	CITY/MUNICIPALITY

PROVINCE	OTHER DETAILS
CONTACT #	
EMAIL ADDRESS	

DO YOU HAVE	SORE THROAT?	[ ] YES	[ ] NO
	FEVER?	[ ] YES	[ ] NO
	COUGH?	[ ] YES	[ ] NO
	RUNNY NOSE?	[ ] YES	[ ] NO
	LOSS OF SENSE OF SMELL?	[ ] YES	[ ] NO
	LOSS OF SENSE OF TASTE?	[ ] YES	[ ] NO
	ABDOMINAL PAIN?	[ ] YES	[ ] NO
	DIARRHEA?	[ ] YES	[ ] NO

DO YOU HAVE ANY RECENT TRAVEL?	[ ] YES	[ ] NO
	IF YES, STATE WHERE:	
	IF YES, STATE DATE OF RETURN TO RESIDENCE:	
DO YOU HAVE EXPOSURE THAT INCLUDES	CONTACT WITH A PROBABLE OR CONFIRMED CASE? [ ] YES [ ] NO	
	WORKED IN OR ATTENDED A FACILITY WITH PROBABLE OR CONFIRMED CASE? [ ] YES [ ] NO	
SIGNATURE:		

By affixing my signature, I attest to the truth and veracity of the above information.
I understand the need for data collection and consent thereto.

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