PHILIPPINE AIR FORCE
520TH AIR BASE WING
AIR FORCE GENERAL HOSPITAL
Colonel Jesus Villamor Air Base, Pasay City

COVID-19 HEALTH DECLARATION FORM

RANK/ SN	LAST NAME	FIRST NAME	MIDDLE NAME
NATIONALITY	AGE	SEX	UNIT ASSIGNMENT
CONTACT NUMBER	HOME ADDRESS		
PLACE OF ORIGIN		DESTINATION	

1. Have you worked or visited, transited or travelled to other places/ countries for the past 14 days?	☐ Yes, (local/ foreign) where:	☐ No
2. Have you visited places of positive COVID-19?	☐ Yes , where:	☐ No
3. Have you been in close contact with person who is a Suspect, Probable of Confirmed case?	☐ Yes, where/ who:	☐ No
4. Did you have any of the following signs and symptoms for the past 14 days? Fever, Cough, Colds, Sore throat, LBM?	☐ Yes, when:	☐ No
5. Did you undergo any COVID-19 test: a. Rapid Anti Body Test ☐ b. RT-PCR (Swab Test) ☐	☐ Yes, when:_____ Where: _____ Result:_____	☐ No
6. Are you living with a friend, family or relative within the same household?	☐ Yes. How many?	☐ No
7. Is there any household members that are working outside?	☐ Yes. How many?	☐ No
8. Is there any confirmed COVID-19 cases from other household member's workplace?	☐ Yes	☐ No

9.Do you live an area with a reported community level transmission?	☐ Yes	☐ No
10. At present, how many are the reported confirmed COVID-19 cases in your BRGY?		
11. How far do you live from the household with a confirmed positive case in your area?		
12. Do you have any possible close contact from those confirmed or probable case?	☐ Yes	☐ No

I do hereby certify that the information provided are true and correct, hence, I assume full liability under RA 11332, otherwise known as Law on Reporting of Communicable Diseases.

_____ **Signature over Printed Name**

_____ **Date and Time**

FOR MEDICAL OFFICER ONLY

Temperature:	**Purpose:**	
Essentially Well Adult at the time of assessment: (Others: _____)	☐ Yes	☐ No
Exhibit any signs and symptoms of COVID-19 for the past 14 days? YES/ NO (Findings: _____)	☐ Yes	☐ No
Fit to Travel (Air/ Land/ Sea):	☐ Yes	☐ No
Fit to Work:	☐ Yes	☐ No

_____ **Physician**

_____ **Date and Time**