HEALTH DECLARATION

The data that you provide is strictly confidential and used for hospital reference only.

Name: _____ Age:___ Sex:___ Contact No.: ______



Due to the recent worldwide outbreak of COVID-19, St. Luke's Medical Center Extension Clinic would like to ensure that our patients/customers and employees are safe from exposure to the disease. In line with this, we are requesting all patients, including companions and visitors, to complete this form.

I am a	[] Patient	[] Visitor	[] Companion	[](Others			
Dlogso	tick an answer for	every question iter	m	Г	YES	NO		
	113	NO						
Have you been tested for COVID-19 in the last 2 weeks?								
Date swabbed: Result (if available):								
Have you been evaluated as Probable or Suspected for COVID-19? If YES, when did your quarantine start?								
Did you have any travel history in the past 14 days?								
If YES, when and where?								
Did you come in close contact or are you staying in the same close								
environment with someone who is a confirmed COVID-19 case?								
Have you	u experienced any o	f the following sympt	oms in the last 2 weeks	?				
	Fever (>38°C)	<i>.</i>						
	Diarrhea, Nausea	, or Vomiting						
	Shortness of brea	ath or other respirato	ry symptoms					
		respiratory symptom						
	Headache							
	Joint Pain or Mus	scle Pain						
	Flu-like symptom	s such as:						
	Chills	or repeated shaking v	with chills					
	Body	aches						
	Sore t	hroat						
	Runny	Nose or Sneezing						
	Cough	n and colds						
	Loss of smell and	/or taste						
	Eye discharge							
	Skin rash or disco	oloration of toes/finge	ers					
	Loss of speech or	movement						
I agree	that the informa	tion provided in thi	is document is true a	nd corre	ct to the be	est of my		
_	-	-	nest answers may ha					
	implications unde		iest unstreis may na		is regulari.	a pasiic		
Heulth	implications and	7 NA 11332.						
l declar	e that all informa	tion disclosed abov	e is TRUE and CORRE	CT.				
Signatu	re:		Date:					
Ü								
Approv	ed entry by: _		Refer	red to:				
		e & signature of as						

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The data that you provide is s	trictly confidention	al and used fo	r hospital reference only.	
Name:	Age:	Sex:	Contact No.:	
Name: Patient [] N	/isitor [1 Companion	[] Others	
tame [] among []		,,		
Please tick an answer for every qu			YES N	0
Have you been tested for COVID-19 in				
Date swabbed: Resul				
Have you been evaluated as Probable of If YES, when did your quara	•	OVID-19?		
Did you have any travel history in the p	oast 14 days?			
If YES, when and where?				
Did you come in close contact or are yo				
environment with someone who is a co	onfirmed COVID-19	case?		
Have you experienced any of the follow Fever (>38°C)	wing symptoms in t	the last 2 weeks	?	
Diarrhea, Nausea, or Vomit	ing			
Shortness of breath or othe		toms		
Other respirator				
Headache				
Joint Pain or Muscle Pain				
Flu-like symptoms such as:				
Chills or repeate	d shaking with chil	ls		
Body aches				
Sore throat				
Runny Nose or S	neezing			
Cough and colds				
Loss of smell and/or taste				
Eye discharge				
Skin rash or discoloration of	f toes/fingers			
Loss of speech or movemer	nt			
I agree that the information provi				-
knowledge and understand that a	ıny dishonest an	swers may ha	ve serious legal and pub	lic
health implications under RA 113	32.			
I declare that all information disclo	osed above is TRI	JE and CORRE	CCT.	
Signature:		Date:		
Annual autorities		Defe	mad ka	

(Name & signature of associate)