**FAMILY HEALTH DISCLOSURE FORM**

*Note: This form shall be accomplished by parents/guardians 1-3 days prior to school opening.*

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| --- | --- | --- | --- | --- | --- |
| **Date:** |  |  |  |  |  |
| **Name:** |  | | | | |
| **Address:** |  | | | | |
| **Contact Number:** |  |  | | | |

|  |  |  |
| --- | --- | --- |
| **Name of Student:** |  | |
| **Grade/Year/Strand/Program:** |  | |
| **Contact Number:** |  |  |

1. **Had anyone in your family been exposed to a confirmed or suspected case two or fourteen days before school started?**

|  |  |  |
| --- | --- | --- |
|  | **YES** | **NO** |
| Face- to- face contact with a confirmed COVID-19 case with in 1 meter and for more than 15 minutes |  |  |
| Direct physical contact with a confirmed COVID-19 case |  |  |
| Direct care for a patient with a probable/confirmed COVID-19 case with or without using proper personal protective equipment (PPE) |  |  |

1. **Have any of your family members been diagnosed as CONFIRMED COVID-19 PATIENTS by your local health worker or hospital in the recent 14 days?**

🞏 Yes, please specify: 🞏 No

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Relationship to the Student** | **Date: Start of quarantine** | **Date: End of quarantine** |
|  |  |  |  |
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🞏 I agree to the collection and processing of my data for the purpose of effecting control of any infectious diseases. I understand that my personal information is protected by RA 10173, Data Privacy Act of 2012, and that I am required provide truthful information. I understand that my personal information shall not be shared or disclosed with other parties without consent unless the disclosure is required by, or in compliance with applicable laws and regulations.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Over Printed Name

*For University Health Department:*

**Recommendations:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- |
|  |  |  |
| *Signature Over Printed Name*  *School Nurse*  *License Number: \_\_\_\_\_\_\_\_\_*  *PTR No: \_\_\_\_\_\_\_\_\_\_\_\_* |  | *Signature Over Printed Name*  *School Physician*  *License Number: \_\_\_\_\_\_\_\_\_*  *PTR No: \_\_\_\_\_\_\_\_\_\_\_\_* |