COVID-19 SELF DECLARATION FORM

Student Name: _____

Registration Number: _____

Student Contact Number: _____

Emergency Contact Person (Parent/Guardian) Name: _____

Contact Number of Parent/Guardian: _____

1. I have experienced the following symptoms in the last 14 days (Tick, wherever applicable) *(Last 14 days should be calculated from the date of travel)*

Sr. No.	Symptoms	YES	NO
1	Fever		
2	Cough/Running Nose		
3	Sore Throat/Running Nose		
4	Breathlessness		
5	Body Ache		
6	Others (Please Specify)		

I have been in close contact with a person infected with COVID-19 in the last 14 days *(Last 14 days should be calculated from the date of travel)*	**YES**	**NO**

2. I have been suspected/confirmed of COVID-19 infection in the last 14 days and/or I am currently under mandatory quarantine: **YES _____ NO _____**
3. My immediate family members have been in close contact with a person infected with COVID-19 in the last 14 days *(Last 14 days should be calculated from the date of travel):* **YES _____ NO _____**

I hereby undertake that the above information submitted by me is true, accurate and complete in all respects. I shall be solely responsible in case any information submitted by me is found false and deemed action may be initiated against me in such case.

Date: _____ Student Signature: _____