COVID-19 DECLARATION FORM

NAME : ……..

AGE : …….. SEX: MALE / FEMALE

STAFF / STUDENT ID : ……

CLASS / DEPARTMENT : ……

MOBILE NUMBER : ……

EMAIL ID : ……

Did you have fever, cough and cold in the last 2 weeks? Yes / No

Did you visit any country in the last 2 weeks? Yes / No

Do any of your family members have the above symptoms? Yes / No

If the answer is **Yes** to any of the above questions please give details:

The above information provided is correct and I understand that this is being collected as a safety measure in view of the COVID-19 epidemic.

Date:

Time: SIGNATURE