**UNIVERSITY OF CEBU DAILY HEALTH SYMPTOMS QUESTIONNAIRE**
**(FOR VISITORS AND NON-EMPLOYEES)**

**Name: _____ Course and Year: _____ Temperature: _____**

**Age: _____ Gender: _____ Nationality: _____ Vaccination Status: _____ Date: _____**

**City/Provincial Address (Please state complete address to include sitio and barangay):**

_____

**Contact Number: _____**

**Purpose of visit: _____**

**Please answer truthfully:**

1. **Have you experience any of the following for the past 2 weeks?** ☐ YES ☐ NO
   **If yes, please check any of the following symptoms:**
   ☐FEVER ☐COUGH ☐BODY PAINS ☐HEADACHE ☐SORETHROAT
   ☐DIARRHEA OR LBM ☐COLDS/RUNNY NOSE ☐LOSS OF SMELL/TASTE
   ☐SHORTNESS OF BREATH ☐SKIN RASHES ☐SORE EYES
   ☐OTHERS (Specify): _____

2. **Is your Sitio or Barangay one of the HOTSPOTS for COVID 19?** ☐ YES ☐ NO

3. **Have you worked/lived together, stayed or been in the same place, house with a confirmed COVID 19 case?** ☐ YES ☐ NO

4. **Have you had any contact with anyone (family, friends, co-workers, neighbor) with fever, cough, colds, sore throat, diarrhea/LBM, loss of smell for the past 2 weeks?** ☐ YES ☐ NO

5. **Have you travelled outside Cebu for the past 2 weeks?** ☐ YES ☐ NO

   If yes, where _____

- Please attach copy of certificate of Completion of Quarantine (for returning foreign students, OFW, Seafarers or patients with Influenza Like Infection/person with history of travel outside Cebu).
- For COVID 19 Survivors, please attach Medical certificate of fit to go back to work from attending Infectious Disease Specialist.

I hereby authorize University of Cebu, to collect and process the data indicated herein for the purpose of effecting control of the COVID 19 infection. I understand that my personal information is protected by RA 10173, Data Privacy Act of 2012, and that I am required by RA 11469, Bayanihan to Heal as One Act, to provide truthful information.

**Signature: _____ Date: _____**