Declaration of Health Status
University Residences

Date: _____ Current Temperature: _____

Do you currently have any of the following symptoms?

			If yes, please describe it's intensity		
	No	**Yes**	Mild	Moderate	Severe
Flu like symptoms					
Dry Cough					
Fatigue / Malaise					
Body Ache					
Headache					
Diarrhoea					
Sore Throat					
Loss of smell or taste					
Any other ailment:					

Social interaction details
Exposure History (Please tick)

	Yes	No	N/A
Someone in my home / my close contact is confirmed COVID-19 +			

Declaration

The information I have provided above is correct.

Signature_____

Personal Details

Name: _____Age: _____ Gender:

Male	Female

Employee/ID Number #: _____

Attending Supervisor: _____ **Date:** _____