MANILA INTERNATIONAL AIRPORT AUTHORITY

HEALTH DECLARATION FORM

_____
Date

TORRES		
Last Name	*First Name*	*Middle Name*

Office / Agency: _____ To be filled out by Medical Staff:
Nationality: _____ Sex: _____ Age: _____ Body Temperature: _____
Contact Number: _____
Email Address: _____
Address in the Philippines: _____
Address Abroad (if applicable) _____

Have you visited or transited from any foreig ☐ Yes *If yes, name of country and travel date:* _____
country in the past 14 days? ☐ No _____
Have you been to any city outside ☐ Yes *If yes, name of city and travel date:* _____
Metro Manila in the past 14 days? ☐ No _____
Have you been sick in the past ☐ Yes *If yes, describe condition:* _____
30 days? _____

		Yes	No	*If yes, please specify:*
A.	Close Contact (1 meter) with confirmed or Probable case of Covid-19	☐	☐	_____
B.	Provided care to a Covid-19 patient without Personal Protective Equipment	☐	☐	_____
C.	Worked with a Covid-19 patient in the last 14 days.	☐	☐	_____
D.	Travelled with a Covid-19 patient in the last 14 day	☐	☐	_____
E.	Lived with a Covid-19 patient in the last 14 days	☐	☐	_____

Did you have any of the following symptoms in the last 14 days:

	Yes	No		Yes	No
Fever	☐	☐	Chills	☐	☐
Cough	☐	☐	Loss of Appetite	☐	☐
Colds	☐	☐	Rashes	☐	☐
Sore Throat	☐	☐	Headache	☐	☐
Difficulty of Breathing	☐	☐	Fatigue / Muscle Pain	☐	☐

Comorbids or any other medical illness: _____

Declaration:

☐ The information I have given above is true, correct, and complete. I shall be held liable for any misdeclaration and same shall be deemed as a violation of pertinent Philippine laws and issuances.

☐ I hereby authorize the MIAA Medical Division to report the above information if requested by BHERT, LGU and Municipal Health Office guided by Republic Act 10173 or the Data Privacy Act.

Informant:

_____
Name and Signature

_____
Date/Time

Thumbmark:

MIAA Medical Officer

_____
Name and Signature