

Health Screening

Name: _____ Date _____

Temperature: _____

Yes No 1. Do you have any history of exposure to COVID-19 patient in the last 14 days?
(Ikaw ba ay may nakasamang may COVID-19 sa nakaraang 14 na araw?)

Yes No 2. Do you have history of travel to an area with high COVID-19 transmission?
(Kayo po ba ay nanggaling sa lugar na may mataas na bilang ng COVID-19?)

Yes No 3. Do you have any symptoms such as sorethroat, body pains, headache, fever and flu like symptoms (cough, colds, fatigue) in the last 14 days?
(Mayroon po ba kayong masakit na lalamunan pananakit ng katawan, sakit ng ulo, lagnat at trangkaso (ubo, sipon, pagkahapo) sa nakaraang 14 na araw?)

Name and Signature
(Pangalan at lagda)

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