Self-Declaration Form for COVID-19

No	Description	Yes	No	Remarks
1	Do you had Fever with cough, sore throat or difficulty in breathing during last 14 days?	◯	◯	....
2	In the past 2 weeks have you been in close (less than 6 feet) prolonged contact (more than 2-3 minutes) with someone suspected or confirmed as COVID-19?	◯	◯	....
3	At the screening point, was your recorded body temperature above 37^{0}C (98.4 ^{0}F)?	◯	◯	....

Date : ..... Time: .....

Name of the guest and group: .....

Passport / ID No: .....

Vehicle number (If applicable): .....

Signature: .....

Accompanying Person if any

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