



**PHILIPPINE OBSTETRICAL
AND GYNECOLOGICAL SOCIETY**

**PHILIPPINE BOARD OF OBSTETRICS AND GYNECOLOGY
HEALTH DECLARATION CHECKLIST**

IMPORTANT REMINDER: *The information collected on this form will be used to determine only whether you may be infected with COVID-19. The information on this form will be maintained as confidential.*

FILL OUT ENTRIES IN BOLD LETTERS

Personal Data:

Name: _____

Last Name

First Name

Middle Name

Sex: Female Age: _____

Male

Contact Address: _____

(HOUSE NO. & STREET)

(BARANGAY)

(TOWN/DISTRICT)

(CITY/PROVINCE)

(COUNTRY/STATE)

(POSTAL/ZIP CODE)

Mobile No/ Telephone No.: _____ Email Address: _____

Place of Work: _____

(If applicable)

Please check if you have any of the following at present or during the past 14 days:

- | | | |
|-------------------------------------------------------------------------------|-------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Fever $\geq 37.5^{\circ}\text{C}$ (oral temperature) | <input type="checkbox"/> Cough | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nausea/Vomiting |
| <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Body Aches | <input type="checkbox"/> Body Weakness |
| <input type="checkbox"/> Difficulty of breathing | <input type="checkbox"/> Loss of Taste or Smell | <input type="checkbox"/> Runny Nose |
| <input type="checkbox"/> Shortness of Breath | | |

Please enumerate, if any, cities in the Philippines you have worked, lived, transited in the past 14 days. _____

Please enumerate, if any, foreign countries you have worked, lived, transited in the past 14 days. _____

Please check the appropriate box

	YES	NO
Did you visit any health worker, hospital, or clinic during the past 14 days?	[]	[]
Were you confined in a hospital or clinic during the past 14 days?	[]	[]
Do you have anyone such as household member/s or close contact/s who are currently having fever, cough and/or respiratory problems?	[]	[]
In the last 14 days, have you been in close contact or exposed to any person suspected of COVID-19?	[]	[]
Have you been in Face-to-face contact with a confirmed case within 1 meter and for more than 15 minutes?	[]	[]
In the last 14 days, have you been in contact with a person confirmed with COVID-19?	[]	[]
When did this person or contact receive a positive RT-PCR test?	_____	

Have you undergone any test for SARS-Cov2 for the past 14 days? [] []

Test Type: RT-PCR Rapid Serology Antibody Test
 Cartridge-based PCR Rapid Antigen Test
 Rapid ECLIA Antibody Test Others, specify: _____

Results: Positive Negative Reactive Non-reactive
 Sample Unfit for Testing Pending

Where was the test done? _____ Date of Release: _____

Note:

IF DONE, THE ORIGINAL OFFICIAL RESULT OF RT-PCR SHOULD BE ATTACHED TO THIS FORM. IN LIEU OF THE RT-PCR, A CERTIFICATE OF QUARANTINE OR ITS EQUIVALENT SIGNED BY LICENSED PHYSICIAN (GOVERNMENT OR PRIVATE PHYSICIAN) OR DULY AUTHORIZED LOCAL OFFICIAL SHOULD BE ATTACHED/SUBMITTED.

**DECLARATION AND
DATA PRIVACY CONSENT FORM**

I submit that the information I have given is true, correct, and complete. I understand that my failure to answer any question, or any misrepresentation of facts or false/misleading information given by me may be used as a ground for the filing of cases against me in accordance with law. I voluntarily and freely consent to the collection and processing of the above personal information only in relation to the IATF Resolution No. 58, series of 2020, pertinent DOH directives, and PRC health and safety protocols.

Name and Signature

Date

Please be advised that the above information shall only be used in relation to the aforementioned protocols in accordance with the Data Privacy Act and Mandatory Reporting of Notifiable Diseases and Health Events of Public Health Concern Act.

Verified by (PBOG Representative/Proctor):

Signature above Printed Name