HEADQUARTERS SUPPORT SERVICE
Self Assessment / Checklist Form

Gate No. ________

Rank/Name:			Date:
Age:	Sex:	Unit:	Mobile Number:
Home Address:			
Workplace Address:		Occupation (for CV/dependents):	

HEALTH CONDITION

Presence of the following:

YES	NO	
		Fever
		Cough (productive or non productive cough)
		Shortness of breath
		Cold
		Sore throat
		Runny nose
		Nasal Congestion
		Muscle pains
		Headache
		Difficulty of Breathing
		Diarrhea
		Loss of sense of Smell
		Loss of sense of Taste
		NONE

If identified with presence of the above, since when?

____

____

TRAVEL HISTORY
(Within the last 14 days)

Specify the place/s where you've been the past few days as well as the date:

____

____

____

If with recent travel, specify the location and date of your travel abroad:

____

____

____

Recent travel in the Philippines:

___NCR

Specify: ____________

____

___Others

Specify: ____________

____

Date: ____________

HISTORY OF EXPOSURE
(Within the last 14 days)

Have you undergone COVID-19 testing:

___ Yes

If yes, Date & Result: ________

___ No

Have you been in close contact with a confirmed case/s of COVID-19?

___ Yes

If yes, Date and Result: ________

___ No

Specify health care facility: ________

Have you been in close contact who works in a healthcare facility/hospital or is currently living with you?

___ Yes

___ No

Specify health care facility where your friend/relative works:

____

Have you been in close contact with a relative or friend who had been to a country or place with confirmed cases of COVID-19?

___Yes

___No

Specify which country and date of close contact with relative or friend:

____

Declaration: The information I have given herein is true, correct, and complete. I understand that failure to answer any question or any falsified response may have serious consequences. (Article 171, & 172 of the Revised Penal code of the Philippines and RA 11332.)

____
SIGNATURE OVER PRINTED NAME

____
SIGNATURE OVER PRINTED NAME OF TRIAGE OFFICER/DATE SIGNED

HEADQUARTERS SUPPORT SERVICE
CONTACT TRACING FORM
(VISITORS)

(Please Fill-Up the Form and Submit to the Duty Sentinel Prior Exit)

NAME(Rank/ /First/Middle/Last Name):			Signature:
Address:			
Date of Visit:		Time In:	Out:
DOB:	Age:	Sex:	
Nationality:	Contact No.		
OFFICE VISITED:			
NAME(Rank/ /First/Middle/Last Name):			Signature:
Address:		Purpose:	
Date of Visit:		Time In:	Out:
DOB:	Age:	Sex:	
Nationality:	Contact No.		
NAME(Rank/ /First/Middle/Last Name):			Signature:
Address:		Purpose:	
Date of Visit:		Time In:	Out:
DOB:	Age:	Sex:	
Nationality:	Contact No.		
NAME(Rank/ /First/Middle/Last Name):			Signature:
Address:		Purpose:	
Date of Visit:		Time In:	Out:
DOB:	Age:	Sex:	
Nationality:	Contact No.		

NOTE: SUBMIT UPON EXIT