לניאדו
מרכז רפואי צאנז
מסונף לבית הספר לרפואה ע"ש רות וברוך רפפורט ▲ הטכניון, חיפה

Declaration Form for a Patient / Companion Regarding Exposure to the Coronavirus COVID-19

Personal information / Label

First and last name: ____________________________ ID: ________________

Please fill in all these details if during the last two weeks you experienced:

Complaints	Fever ☐ Shivers ☐ Vomiting ☐ Cough ☐ Headaches ☐ Diarrhea ☐ Sore throat ☐ Muscle pain ☐ Loss of smell/taste ☐ Breathlessness ☐ Abdominal pain ☐ Other:___________
Active disease	Have you been diagnosed as a coronavirus COVID-19 carrier: Yes / No (if yes – date of the test ______________________)
Stayed abroad during the last month	Yes / No
Known exposure to a confirmed or suspected case of COVID-19 or any other infectious disease	Has one of your family members had a fever / runny nose / cough / sore throat or any kind of infection? Yes / No Has someone you have been in contact with been in quarantine during the last two weeks? Yes / No Have you been exposed to a confirmed / suspected corona patient? Yes / No If yes, what was the date of exposure: _____________

Sharing the details above will not prevent proper medical treatment.

I hereby declare that all the details noted above are true, and I am aware that concealing information is liable to pose a danger to public health and endanger the medical team.

Date: ___/___/______ Time: ___:__

Full name: ______________________ Signature: ____________________