Health Declaration Form Travel

Traveler Information

Full Name: ____

Passport Number: ___________________________________

Date of Birth (DD/MM/YYYY): _________________________

Travel Destination: __________________________________

Contact Number: ____________________________________

Health Condition

Have you experienced any of the following symptoms in the past 14 days?

Fever: Yes / No

Cough: Yes / No

Difficulty Breathing: Yes / No

Other Symptoms (Please specify): ______________________

Have you been in contact with anyone diagnosed with COVID-19?

Yes / No

If yes, please provide details: __________________________

Vaccination and Test Information

Have you received a COVID-19 test in the past 72 hours?

Yes / No

If yes, provide date of test: _____________________________

Have you been fully vaccinated?

Yes / No

If yes, provide vaccination date: _________________________

Declaration

I confirm that the information provided is accurate, and I am fit for travel.

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Signature: ____

Date: ____

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