

## DECLARATION OF HEALTH STATUS

**Date:** .....

**Organization:** .....

**First name(s):** .....

**Surname:** .....

**Date of birth:** .....

**Document No.:** .....

**Document issued by (country):** .....

**Have you visited a foreign country in the last month?**  YES /  NO

**What countries have you visited?** .....

**In which dates have you been there?** .....

**Do you have any medical symptoms** (a cough, runny nose, fever, difficulty breathing)?  
 YES /  NO

**Contact with infected persons:**  YES /  NO    **When:** .....

**Telephone number:** ..... **E-mail address:** .....

**Signature:** .....