Republic of the Philippines
NATIONAL POLICE COMMISSION
PHILIPPINE NATIONAL POLICE
HEADQUARTERS SUPPORT SERVICE
Camp BGen Rafael T Crame, Quezon City

Self Assessment / Checklist Form

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