

# Travel & Health Declaration Form

Due to the COVID-19 pandemic, we will require everyone coming into the school to fill this declaration form to ensure the safety of every occupant in our school grounds for us to keep track of the health and whereabouts of our occupants. Should you choose not to fill this form or disclose details which are required, the school reserves the right to deny your entry to the school. Your cooperation is greatly appreciated.

Name as per NRIC/ Passport:		NRIC/ Passport Number:	
Mobile Number:		Nationality:	

Reason for Visit or Entry:	<input type="checkbox"/> Attend School (Class name: _____)	<input type="checkbox"/> Course Enquiry	<input type="checkbox"/> Payments
	<input type="checkbox"/> Meetings* <i>(*Pre-approval required)</i>	<input type="checkbox"/> Delivery / Services	<input type="checkbox"/> Others: _____

Details of the Personnel you are meeting:			
Name of personnel:		Mobile contact:	
Department:		Email address:	

Question	Self-Declaration		
1	Do you have any of the following symptoms now? *		
	<input type="checkbox"/> None of the above	<input type="checkbox"/> Fever	<input type="checkbox"/> Flu / Common Cold / Runny Nose
	<input type="checkbox"/> Cough / Dry Cough	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Body Aches
	<input type="checkbox"/> Loss of Taste or Smell	<input type="checkbox"/> Rash on Skin	<input type="checkbox"/> Headache
	<input type="checkbox"/> Diarrhoea		
2	Have you traveled out of Malaysia in the last 30 days? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	<i>If you have ticked "Yes", please fill up below:-</i>		
	List all countries visited in the last 30 days:		
	Latest travel Departure Date	:	
Latest travel Return Date	:		
3	Have you been fully vaccinated, as defined by MKN & KKM, & as shown in MySejahtera, i.e., have had 2 vaccine doses & more than 14 days after 2 <sup>nd</sup> dose? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Date of 2 <sup>nd</sup> dose : _____	Date of 3 <sup>rd</sup> dose (booster) :	_____

4	<p>Have you, to the best of your knowledge, come in contact with someone who had been infected by COVID-19 in the last 30 days?</p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>
5	<p>Have you been tested positive for Covid-19:</p> <p>In the last 14 days?    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>In the last 30 days?    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>If yes to the above, have you been cleared/tested negative since then?</p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p> <p>Have you taken the Covid-19 detection swab test in the last 14 days?</p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p> <p>If yes:</p> <p>(a) Please state latest swab test date: _____</p> <p>(b) Type of test taken:</p> <p><input type="checkbox"/> RT-PCR    <input type="checkbox"/>          RTK Antigen</p> <p>(c) What was the test result?</p> <p><input type="checkbox"/> Positive (+ve)      <input type="checkbox"/> Negative (-ve)</p> <p>(d) What were the circumstances that required or made you take the test?</p> <p>_____</p> <p>_____</p>

***This declaration has TWO pages, please fill up both pages.***

*I declare that all the information entered here is correct and accurate as of the time of submission of this declaration.*

*Kindly take note this is a legally binding document requiring factually correct & accurate information.*

Signature : \_\_\_\_\_

Date of Entry : \_\_\_\_\_