**COVID-19 HEALTH DECLARATION OF A VISITOR AT A SOCIAL WELFARE INSTITUTION**

First name and surname Insert name and surename

Personal code Insert personal code

First name and surname of the person to be visited Insert name and surename

Date of the visit Insert date

1. Have You or anyone from Your household been in contact with a person infected with COVID-19 within the last 14 days?

[ ]  Yes, when [ ]  NO

2. Do You have at least one of the following symptoms?

[ ]  Yes (select symptoms) [ ]  NO

[ ]  ‒ fever over 37,5 C

[ ]  ‒ cough

[ ]  ‒ sore throat

[ ]  ‒ breathing difficulties, shortness of breath

[ ]  ‒ loss of taste and smell

[ ]  ‒ muscle aches

[ ]  ‒ unusual fatigue

[ ]  ‒ other other

3. Have You previously been tested for COVID-19 with a POSITIVE result?

[ ]  Yes, when when [ ]  NO

4. Have You been abroad within the last 14 days?

[ ]  Yes, where: where [ ]  NO

 Insert date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_

 /digital signature/ / date of the digital signature /