



ANDA, Pangasinan

COVID-19 HEALTH DECLARATION FORM (HDF) v4.0

All persons entering the Municipality of Anda from outside Pangasinan shall furnish all the information required in this form for the safety of everyone in this pandemic time. This form is to be used only for travels to Anda, Pangasinan.

The information herein will be used in accordance to law and to contact you in such cases of any transmission of COVID-19. This form shall be kept with confidentiality and with privacy. Kindly fill out completely and accurately.

PART 1 (Please fill in as much as possible where appropriate)				GENERAL INFORMATION	
Full Name <small>(First name M.I. Last name)</small>				Age	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Nationality		Phone No.	
ID No.		ID Type:		Email	
Origin Address <small>Town/City & Province</small>				Travel Date <small>from origin</small>	
Destination Address <small>or resort accommodation</small>				Arrival Date <small>at destination</small>	
Last Place of Stay <small>in origin address, e.g. home</small>				Duration of Stay <small>in Anda, Pangasinan</small>	<input type="checkbox"/> Day trip only <small>(until curfew)</small>
Passport No. <small>(if applicable)</small>		Flight No. <small>(if applicable)</small>		Seat No. <small>(if applicable)</small>	
Purpose of Travel <small>Resident of Anda, Tourist, Working in Anda, Official Travel, etc.</small>	Vaccination Status <small>(Please attach your vaccine card)</small>		<input type="checkbox"/> Not yet vaccinated <input type="checkbox"/> Received the second or final dose less than two weeks ago <input type="checkbox"/> Waiting for second dose <input type="checkbox"/> Fully vaccinated (at least two weeks after receiving the final dose)		

PART 2 (Self-check: Do not answer earlier than 3 days before travel)		COVID-19 INFORMATION																																					
1. Have you been to any ECQ/MECQ/GCQ with Restriction areas or travel-banned countries over the past 14 days? <small>* (as indicated by IATF/DOH/DFA/other relevant agencies)</small>		<input type="checkbox"/> Yes	<input type="checkbox"/> No																																				
1.A If yes, please specify:																																							
2. Have you been in contact with a confirmed case of COVID-19 in the past 14 days?		<input type="checkbox"/> Yes	<input type="checkbox"/> No																																				
3. Do you have any of the ff. symptoms? (Put a check mark ✓ or slash / in the column of your answer)																																							
<table border="1"> <thead> <tr> <th>Symptoms</th> <th>YES</th> <th>NO</th> <th>Symptoms</th> <th>YES</th> <th>NO</th> </tr> </thead> <tbody> <tr> <td>a. Fever</td> <td></td> <td></td> <td>f. Loss of Taste</td> <td></td> <td></td> </tr> <tr> <td>b. Cough</td> <td></td> <td></td> <td>g. Loss of Smell</td> <td></td> <td></td> </tr> <tr> <td>c. Difficulty of breathing</td> <td></td> <td></td> <td>h. Diarrhea</td> <td></td> <td></td> </tr> <tr> <td>d. Sore throat</td> <td></td> <td></td> <td>i. Vomiting</td> <td></td> <td></td> </tr> <tr> <td>e. Fatigue / Tiredness</td> <td></td> <td></td> <td>j. Other symptoms (please specify)</td> <td></td> <td></td> </tr> </tbody> </table>		Symptoms	YES	NO	Symptoms	YES	NO	a. Fever			f. Loss of Taste			b. Cough			g. Loss of Smell			c. Difficulty of breathing			h. Diarrhea			d. Sore throat			i. Vomiting			e. Fatigue / Tiredness			j. Other symptoms (please specify)				
Symptoms	YES	NO	Symptoms	YES	NO																																		
a. Fever			f. Loss of Taste																																				
b. Cough			g. Loss of Smell																																				
c. Difficulty of breathing			h. Diarrhea																																				
d. Sore throat			i. Vomiting																																				
e. Fatigue / Tiredness			j. Other symptoms (please specify)																																				
4. Do you suffer from any chronic diseases? <small>(hypertension, diabetes, asthma, heart disease, kidney disease, cancer, arthritis, etc.)</small>		<input type="checkbox"/> Yes	<input type="checkbox"/> No																																				
4.A If yes, please specify:																																							
5. Have you engaged yourself in certain group activities?		<input type="checkbox"/> Yes	<input type="checkbox"/> No																																				
5.A If yes, please specify:																																							

PART 3 (to be signed with guardian's name and signature if minor)		DECLARATION	
----- SIGNATURE (required) -----		----- DATE OF SIGNING (required) -----	
<p>By affixing my signature, I attest to the truth and veracity of the above information. I understand the need for data collection critical to the COVID-19 situation and consent thereto.</p>			

THIS FORM IS CONSIDERED VALID ONLY IF THERE IS SIGNATURE AND DATE OF SIGNING. DO NOT DATE THIS FORM WITH A FUTURE DATE.

THIS FORM IS ONLY VALID FOR 3 DAYS (72 HOURS) FROM THE DATE OF SIGNING AND MUST BE VALID ON THE DATE OF TRAVEL.

PLEASE SUBMIT A PHYSICAL COPY OF THIS FORM TO THE CHECKPOINT PERSONNEL AT THE ANDA BRIDGE UPON ENTRY.

A blank copy of this form is available for download at www.andapangasinan.gov.ph | This form may be reproduced and distributed but is not for sale.