(Declaration/Screening form for COVID-19 Infection)

Date :___/___/20___

Name of the Student/Faculty/Staff: _____ Mobile No. (Self)_____

Father's Name: _____ Mobile No. : _____

Name of Thesis Supervisor/Mentor (for PG Students only) _____ Mobile No. :_____

Roll No. / PF No.: _____ Programme: _____ Age: ____ Gender: M/F Email ID: _____

Correspondence Address: _____

_____

Permanent Address: _____

_____

COVID 19 Questionnaires

1.	Do you have symptoms of Fever, Cough, Sneezing, Sore Throat, Fatigue and Myalgia?	Yes	No
2.	Do you have difficulty in breathing?	Yes	No
3.	Complete address, from which place you have started your journey?		
Mention the name of city?			
4.	Is your travel address currently in the Containment zone?	Yes	No
5.	Have you travelled inside India to other cities in past 15 days?	Yes	No
If Yes, Mention the cities.			
6.	Exposure to a confirmed COVID-19 case OR to Suspicious patient in last two week?	Yes	No
7.	Have you visited a health care facility in the past two weeks?	Yes	No

The above information is true to the best of my knowledge. I understand that withholding/concealing the above information is unethical and against the interests of the global population fighting the COVID-19 pandemic.

During this unlock___ in the wake of the current COVID-19 pandemic, I have reached to the Institute by myself, voluntarily to continue my Research work/Official work. If I am an asymptomatic carrier or and undiagnosed with COVID-19, I suspect it may endanger Institute/Doctors/Faculty/Staff/Other Students, and therefore, it is my responsibility to take appropriate precautions and to follow the protocols prescribed by Government of India and other healthcare Institutions.

Despite all efforts taken by Institute Hospital/Doctors/Registrar office to prevent COVID-19 which is explained to me, I understand that I may get an infection form the any person, and I will take all precautions to prevent this from happening, but I will not at hold Institute Hospital/Doctors/Registrar office accountable if such infection occurs to me or my accompanying persons.

If I hide my fact and relevant details and because of my intentionally or unintentionally behaviour or action OR if any healthcare personnel gets infected, I will be held responsible and appropriate legal action shall be taken against me.

Name: _____ Mobile Number: _____ Signature: _____

For Primary Health Centre Use Only

- **Body Temperature :** _____ °F **BP :** _____mm/_____hg **Pulse :** _____/ mins **SPO_2:** _____
- **Any symptoms of Covid-19:** Found/Not Found **If found, type of Symptoms:**_____
- **Homemade face mask:** Available/Not Available
- **Sanitizer bottle (500ml) :** Available/Not Available
- **Name of the Doctor/Nursing Assistant:** _____**Signature and Seal**