INDIAN INSTITUTE OF PETROLEUM & ENERGY

SELF DECLARATION FORM / HEALTH SCREENING FORM

Name:

Roll Number:

Branch & Semester:

Contact Number:

Email Address :

Faculty Mentor & DIC:

Did you suffer from / tested positive for COVID 19 infection?

Yes

No

Was any of your family members tested positive for COVID 19 infection?

Yes

No

Were / Are you in close contact with any positive or suspected case for COVID 19?

Yes

No

Did / Do any of your family members has cloase contact with a positive or suspected patient of Covid 19?

Yes

No

Were you isolated or quarantined by COVID 19 team?

Yes

No

Was any of your family member isolated of quarantined by COVID 19 team?

Yes

No

Are you suffering form any of the following symptoms?

	Yes	No
Fever	◯	◯
Cough	◯	◯
Difficulty in Breathing	◯	◯
Sore Throat / Running Nose	◯	◯
Headache and Malaise	◯	◯

Is any of your family member suffering from:

Fever	◯	◯
Cough	◯	◯
Difficulty in Breathing	◯	◯
Sore Throat / Running Nose	◯	◯
Headache and Malaise	◯	◯

Are you suffereing from any chronic illness like Diabetes Mellitus, Hypertension, Hear disease etc or no immunosupressant drugs?

Yes

No

If Yes, Provide details

Your Answer:

Are you presently staying at a location during lockdown which is the containment zone of COVID 19?

Yes

No

Did you have a history of travel outside in the last 4 weeks?

Yes

No

If Yes, from where? Any history of contact with a suspected / a positive case of COVID 19 during this travel?

Your answer:

Did you suffer from any psychological problem in the last 4 weeks?

Yes

No

If yes, please give details

Your answer:

I hereby declare that all the above details are true.

Student Name

Roll No

Signature

Mbl No.

Parent Name

Signature

Mbl No.