SAN BEDA UNIVERSITY

HEALTH OFFICE

San Beda University ensures the health and safety of individuals entering and leaving the university premises and campus. The following information is necessary in line with coronavirus (Covid-19) monitoring, contact tracing, and prevention.

The University, guided with Benedictine values, is bound by its benevolent duty to report covid-19 cases, to authorities, in its commitment to community and country, to help in the flattening of the pandemic curve. Coronavirus cases in the campus shall be dealt with utmost and strict confidentiality.

We respectfully request for your cooperation. Thank you.

Name: ______________________ ___________________________ __________________
(Last Name) (First Name) (Middle Name)

Age: __________ Gender: ( ) Male ( ) Female

Address: ____
Barangay ______________ City ___________________________________
Region ( ) Metro Manila
( ) Provincial: Specify which province: ____________________

Contact numbers: ____

Occupation: ( ) Student
Course/School level ______________________
Year and section _________________________

( ) Faculty/Employee/working
For San Beda employee/Faculty:
Specify Department ______________________________________

Do you have a history of travel (Philippines and abroad) during the last fourteen (14) days?
( ) Yes ( ) No.

If you answered yes in the preceding, please specify places you been into:
____
____

Do you experience any of the following: ( ) fever ( ) cough ( ) headache
( ) difficulty of breathing ( ) body weakness ( ) fatigue ( ) vomiting
( ) nausea ( ) diarrhea ( ) other symptom,
pls. specify __________________

Were you in contact with a sick person/family member or anybody with the above enumerated symptoms during the last fourteen (14) days? ( )Yes ( ) No

In case of sickness/emergency: Parent/guardian/spouse/family member
Name(s) ____
Contact numbers ____

Please provide us with your recent and past medical/surgical history as medical database for us to identify co-existing conditions that can redound to your own health and safety benefit.

Hypertension ( ) yes ( ) no
Diabetes ( ) yes ( ) no
Asthma ( ) yes ( ) no
Pneumonia ( ) yes ( ) no
If yes, when were you diagnoses/hospitalized ______________

Cancer ( ) yes ( ) no
If yes, what type _________, Year diagnosed ______________

Surgery ( ) yes ( ) no
If yes, what year __________ and for what Condition ______________
____

Hospitalization ( ) yes ( ) no
If yes, when _________ and for what condition ______________

Other conditions
____
____

(Signature over printed name)

Date ______________________