Republic of the Philippines
Department of Environment and Natural Resources XI
Mount Hamiguitan Range Wildlife Sanctuary
PROTECTED AREA MANAGEMENT OFFICE
PENRO Davao Oriental, Gov't Center, Mati, Davao Oriental
Tel. No.: (+63) (087) 388-3275 (PENRO);
Email: hamiguitan.protect@gmail.com

UNESCO World Heritage Site
& ASEAN Heritage Park

ARRIVAL HEALTH DECLARATION FORM

IMPORTANT NOTE: Due to the threat of the COVID-19 pandemic and pursuant to the set guidelines recommended by the Inter-Agency Task Force against COVID-19, the Protected Area Management Office of Mount Hamiguitan Range Wildlife Sanctuary, in collaboration with the straddled LGUs of the protected area, comply with the government directive related to travel restrictions due to the current health situation.

Relative to this, as our guest/client, may we require you to fill out this form truthfully, to be attached with a copy of your valid Identification Card. Kindly write legibly. If the item is not applicable in your case, please put 'N/A'in the space provided after. Tick a check mark on items with the correct answer of your choice.

FULL NAME (Surname, First Name, Middle Name) _____	**AGE**	**GENDER**	**NATIONALITY**	**TEMPERATURE**
COMPLETE PRESENT ADDRESS _____				
CONTACT DETAILS	**Mobile/ Telephone No.**	**E-mail**		
TYPE OF ID PRESENTED WITH ID NO.				

1. Countries visited in the past two (2) weeks. _____
2. Local destination/s visited in the past two (2) weeks. _____
3. Have you visited a Hospital or Clinic in the past two (2) weeks? [ ] YES [ ] NO
4. Have you ingested any medication for fever in the last four to six (4-6) hours? [ ] YES [ ] NO
5. Have you visited aby poultry farm or animal market in the past fourteen (14) days? [ ] YES [ ] NO
6. Put a check mark beside the following signs and symptoms **IF** you **EXPERIENCED** them in the past fourteen (14) days.

[ ] Headache [ ] Difficulty in breathing

[ ] Cough [ ] Body Weakness

[ ] Cold [ ] Unexpected Bruising or bleeding

[ ] Sore Throat [ ] Others (please specify):_____

7. Do you have specific allergy from any food or medication? [ ] YES [ ] NO
   If YES, please specify: _____

I hereby declare the above information true and correct.

_____ _____
Signature above Printed Name Date

==========TO BE FILLED OUT BY MHRWS-PAMO==========

RECEIVED BY: _____ DATE: _____ SIGNATURE: _____

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