GESUNDHEIT AROSA

COVID-19 – FORM

Surname _____ First name _____

Date of birth _____ Sex ☐ m ☐ f

Street/No. _____ Canton/Country _____

ZIP/City _____ Nationality _____

Phone _____ E-Mail _____

Health insurance _____ Insurance-No. _____

Employer _____ Profession _____

Hotel/appartement _____

Arrival _____ Departure _____

Symptoms **Start of symptoms** _____

☐ Fever ≥ 38 °C ☐ Cough ☐ Shortness of breath ☐ Diarrhea
☐ Headache ☐ Loss of smell ☐ Loss of taste
☐ other:

Pre-existing illnesses

☐ Diabetes mellitus ☐ Cardiovascular ☐ Immunosuppression ☐ Renal disease
☐ High blood pressure ☐ Cancer ☐ Respiratory disease ☐ Overweight
☐ other:

Height _____ **Weight** _____ **Smoker** ☐ yes ☐ no

Smoker ☐ yes ☐ no **Pregnancy** ☐ yes ☐ no ☐ possible

Contact with confirmed COVID-19 person during the last 2 weeks ☐ yes ☐ no

If yes, when and where? _____

By whom? ☐ Family ☐ Work ☐ As medical staff
☐ School/preschool/day care ☐ other: _____

Were you contacted by the authorities/Contact Tracing ☐ yes ☐ no

Already in quarantine/isolation? ☐ yes ☐ no Since when? _____

Swiss Covid App ☐ yes ☐ no

Result to my E-Mail ☐ yes ☐ no **Language** ☐ DE ☐ EN ☐ FR ☐ IT

I hereby confirm, that I have truthfully answered the above questions.

_____ _____

Place, date Signature

GESUNDHEIT AROSA

alterszentrum ambulanz spitex medizinisches zentrum

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Contact persons (for contact tracing)

The health department has ordered us to gather and send all contacts of COVID-19-patients. Please fill in the form below with the persons you had close contact to from 48 hours before the first symptoms appeared until now. Close contact is defined as less than 2 meters, for more than 15 minutes, without protective measures (mask).

Surname ______________________ First name ______________________
Date of birth ______________________ Sex ☐ m ☐ f
Street/No. ______________________ Phone ______________________
ZIP/City ______________________ E-Mail ______________________

Surname ______________________ First name ______________________
Date of birth ______________________ Sex ☐ m ☐ f
Street/No. ______________________ Phone ______________________
ZIP/City ______________________ E-Mail ______________________

Surname ______________________ First name ______________________
Date of birth ______________________ Sex ☐ m ☐ f
Street/No. ______________________ Phone ______________________
ZIP/City ______________________ E-Mail ______________________

Surname ______________________ First name ______________________
Date of birth ______________________ Sex ☐ m ☐ f
Street/No. ______________________ Phone ______________________
ZIP/City ______________________ E-Mail ______________________

Surname ______________________ First name ______________________
Date of birth ______________________ Sex ☐ m ☐ f
Street/No. ______________________ Phone ______________________
ZIP/City ______________________ E-Mail ______________________

Please fill in another form, if there are more contact persons.

Remarks/further informations (for example: School? Class?)

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