



GESUNDHEIT AROSA

COVID-19 form

All information is treated confidentially

Personal data

Surname _____ First name _____

Date of birth _____ Sex m f _____

Adress _____ ZIP / City _____

Canton / Country _____

Nationality _____

Phone _____

E-Mail _____

Health insurance _____

Insurance-No. _____

Employer _____ Profession _____

Hotel / appartement _____

Arrival _____ Departure _____

Symptoms

Start of symptoms _____

Fever $\geq 38^{\circ}\text{C}$

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 _____ Pregnancy yes no possible _____



I had contact with a diseased person yes no

If yes, when and where? _____

Through whom? Family School / preschool / day care
 Work as medical staff
 other: _____

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 _____

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

Adress _____ ZIP / City _____

Phone _____ E-Mail _____

Surname _____ First name _____

Date of birth _____ Sex m f

Adress _____ ZIP / City _____

Phone _____ E-Mail _____

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

Remarks / further informations (for example School and Class)



Surname	First name
Date of birth	Sex m f
Adress	ZIP / City
Phone	E-Mail

Surname	First name
Date of birth	Sex m f
Adress	ZIP / City
Phone	E-Mail

Surname	First name
Date of birth	Sex m f
Adress	ZIP / City
Phone	E-Mail

Surname	First name
Date of birth	Sex m f
Adress	ZIP / City
Phone	E-Mail

Surname	First name
Date of birth	Sex m f
Adress	ZIP / City
Phone	E-Mail

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

Remarks / further informations (for example School and Class)

