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Health Certificate

Date: / /

Client Name: Gender: Age:
Hospital ID:
Date of Birth:
Past Medical History:
Present Illness:

Assessment

1) Close contact with a person with COVID-19 (probable or confirmed) while they were ill without taking appropriate precautionary measures within the last two weeks

☐ Yes ☐ No

2) Clinical symptoms such as cough, shortness of breath, chills, fatigue, muscle pain, headache, sore throat, vomiting, diarrhea, or new loss of taste or smell.

☐ Yes ☐ No

3) Clinical Manifestation

Vital signs

Blood pressure: / mmHg
Pulse rate: bpm
Body temperature: ℃
Oxygen saturation (SpO2): % on room air

Physical findings

Heart sound: regular rhythm, no murmur
Respiratory sound: no rales, no wheeze
Others: No remarkable findings

4) Laboratory result (Date / /)

Real-time PCR test for SARS-CoV-2 (Nasal Swab): Negative (Not detected)

Comments:

Based on the above information, the person named above is currently healthy and unlikely infected with SARS-CoV-2. Therefore, [he or she] is fit for [flight and/or work] at the current health condition.

Physician's name:
Signature:

Department of Infectious Diseases,
Kobe University Hospital