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Struttura convenzionata con
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BIALLO

SELF-CERTIFICATION LAW DECREE n. 445/2020

The undersigned

Fiscal code		Nationality	
Name		Surname	
Date of birth		Place of birth	
Domicile	Street/square/ave	Town	
e-mail		Phone n°	
card/pass n°			

In the case of a minor: as father / mother / legal guardian of___________________________
born on ____/____/____ in ___________________________ province_____,
resident at ___________________________ province _____)

Aware of criminal responsibility for untruthful statements

DECLARES

to be in the conditions provided for by the regional council resolution of 21st Oct 2020 n. 1705:

- To be asymptomatic;
- Not to be quarantined and/or cohabiting with a quarantined person.

DECLARES

That I have read and understood the health information and I have had the opportunity to speak with a health professional in order to receive any further information concerning this.

REQUIRES

the execution of the **ANTIGENIC** test for the research of *Sars-CoV-2* for:

☐ Work/professional matters;
☐ Travel matters;
☐ Requests not related to clinical or public health needs already governed by regional national measures.

Date:___/___/___ Signature: ______________________________________

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HEALTH INFORMATION FOR THE CONSENT TO THE EXECUTION OF THE ANTIGENIC BUFFER FOR THE RESEARCH OF SARS-COV-2

COVID-19 is the abbreviation for ***CO****rona* ***Vi****rus* ***D****isease 2019*, or the disease caused by the new *SARS-CoV2* coronavirus. The antigenic :

- It allows to check the presence of the virus and therefore the possibility of infecting other people;
- It does not allow to define information about the immunological status or about the presence of immune defenses against the virus.

TRIAGE

1) Have you ever performed a molecular test and / or antigen test for SARS-CoV2?

Yes	No

2) Have you ever been tested positive for SARS-CoV2?

Yes, day___/___/___	No

3) Have you stayed abroad during the last 15 days?

Yes, at __________	No

4) Have you had, in the past 14 days, risky contact with a suspected or confirmed case of *SARS-CoV2* infection?

Yes, date___/___/___	No

5) During the past 14 days, have you had one or more of the following symptoms?

- ☐ Temperature superior of 37.5°
- ☐ Cough/ throatache Breathing
- ☐ difficulty
- ☐ Gastrointestinal disorders
- ☐ Alteration of taste / smell
- ☐ Muscle aches and exhaustion

6) Are you suffering from chronic diseases?

Yes_______________	No

Date:___/___/___ Signature: _________________________________