

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: _____



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 *COrona Virus Disease 2019*, or the disease caused by the new *SARS-CoV2* coronavirus. The antigenic :

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

TRIAGE

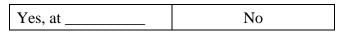
1) Have you ever performed a molecular test and / or antigen test for SARS-CoV2?



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

Yes, day//	No
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3) Have you stayed abroad during the last 15 days?



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

Alteration of taste / smell Muscle aches and exhaustion

Gastrointestinal disorders

6) Are you suffering from chronic diseases?

Yes No

Date:___/___/

Signature: _____