TRAVELER HEALTH DECLARATION FOR PRIMARY EXIT SCREENING

_____
Date and Time

Each traveler needs a separate form.

Family name: _____ First (given) names: _____

Citizenship_____ Country of residence: _____

Birth date: ___ /___ / ___ (Day/Month/Year) Sex: Male ☐ Female ☐

Flight number:_____ Date of destination arrival: ___ /___ / ___ (Day/Month/Year) Seat number on plane:_____

Final destination address: _____

_____City: _____

State/Province: _____ Country: _____ E-mail address: _____

Do you have a mobile phone? Yes ☐ No ☐ Mobile number: _____

TODAY, OR IN THE PAST 72 HOURS, HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS?

- Fever (100.4° F / 38° C or higher)
- Cough
- Shortness of Breath or Difficulty breathing
- Chills or Repeated Shaking with Chills
- Sore Throat
- Diarrhea
- Muscle Aches
- New loss of smell or taste

YES ☐ **NO** ☐

- **IN THE PAST 14 DAYS**

1. Have you visited, worked in or been hospitalized in any health care facility? **YES** ☐ **NO** ☐
   a) City where facility is located:
      _____
   b) Date of last visit or discharge: ____/____/____ (Day/Month/Year)

2 . Have you had contact with a person known to be infected with (COVID-19) (novel coronavirus disease)? **YES** ☐ **NO** ☐

3. If yes to # 2
   a) What was your relationship to the person(s) (friend, colleague, family member, spouse)?
      _____
   b) Did you have close contact (within 6 feet/2 meters)? **YES** ☐ **NO** ☐
   c) Did you provide care to the person? **YES** ☐ **NO** ☐
      i. If yes, where? Check one: Home _____ Health care facility _____

TO BE COMPLETED BY SCREENING STAFF

Temp ☐ Visible signs of illness: ☐ Yes ☐ No Screener:_____

☐ Cleared for travel ☐ Referred for secondary screening

30 April 2020 PREVIOUS EDITIONS ARE OBSOLETE

THIS INFORMATION IS SUBJECT TO THE PRIVACY ACT OF 1974