



MINISTRY OF HEALTH, WELLNESS AND ELDERLY AFFAIRS
HEALTH SCREENING QUESTIONNAIRE

(To be completed by all adult passengers prior to disembarkation)

Traveler Information:

First Name (s): _____

Last Name (s): _____

Date of Birth (dd/mm/yy): _____

Country of Residence: _____

Intended Address in Saint Lucia: _____

Telephone Number: _____

Name and date of birth of all children (under 18 years) travelling with you:

Within the past 21 days have you, or any person listed above:

- | | | |
|--|------------------------------|-----------------------------|
| 1. Been diagnosed with a contagious disease? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. Had close contact with anyone diagnosed with a contagious disease? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3. Provided direct care for patients with contagious diseases? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 4. Visited any patient having a contagious disease? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 5. Worked/stayed in a closed environment with someone with a contagious disease? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 6. Lived in the same household as someone with a contagious disease? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

If the answer to any of the questions above is 'yes', please specify illness: _____

Within the past 21 days have you, or any person listed above experienced any of the following symptoms (check all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Vomiting/nausea | <input type="checkbox"/> Headache | <input type="checkbox"/> Fever >38.5°C |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Muscle pain (myalgia) | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Fatigue /extreme weakness | <input type="checkbox"/> Swollen lymph nodes |
| <input type="checkbox"/> Loss of smell/taste | <input type="checkbox"/> Sore throat | <input type="checkbox"/> Red/Pink eye |
| <input type="checkbox"/> Bleeding: <input type="checkbox"/> Eyes <input type="checkbox"/> Nose | <input type="checkbox"/> Rash: Specify site:_____ | |
| <input type="checkbox"/> Mouth <input type="checkbox"/> Other:_____ | _____ | |

I, _____, hereby declare that the above information is correct. I acknowledge that any false declarations on this form is subject to a fine of XCD \$1,000.00.

Signature

Date