

Pre-boarding health declaration questionnaire

(The questionnaire is to be completed by all adults before embarkation)

Name of vessel:	Shipping Company:	Date & time of itinerary:	Port of disembarkation:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Contact telephone number for the next 14 days after disembarkation:

Full name as shown in the Identification Card/Passport:	Father's Name:	Seat:	Number:
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D	<input type="text"/>

Full name of all children travelling with you who are under 18 years old:

<input type="text"/>	<input type="text"/>	A) Economy B) Aircraft type C) Business, D) Cabin	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D	<input type="text"/>

Within the past 14 days	YES	NO
Have you or has any person listed above, presented sudden onset of symptoms of fever or cough or difficulty in breathing?	<input type="checkbox"/>	<input type="checkbox"/>
Have you, or has any person listed above, had close contact with anyone diagnosed as having coronavirus COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
Have you, or has any person listed above, provided care for someone with COVID-19 or worked with a health care worker infected with COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
Have you, or has any person listed above, visited or stayed in close proximity to anyone with COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
Have you, or has any person listed above, worked in close proximity to or shared the same classroom environment with someone with COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
Have you, or has any person listed above, travelled with a patient with COVID-19 in any kind of conveyance?	<input type="checkbox"/>	<input type="checkbox"/>
Have you, or has any person listed above, lived in the same household as a patient with COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>

Have you been tested within the past 14 days for COVID-19?
 No
 Pending results
 Positive
 Negative

Signature _____