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 (under18 years) travelling with you:

_____ _____

_____ _____

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

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

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):

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