MINISTRY OF HEALTH AND WELLNESS
HEALTH SCREENING QUESTIONNAIRE
(to be completed by all adult passengers prior to disembarkation)

Name as shown on the passport

Passport No.

Home Address

Intended address in Saint Lucia:

For hotel stays – Property Name

For returning nationals and residents – does your home meet the conditions for home quarantine? Do you live alone or have access to your own bedroom and bathroom?

Yes √ No □

If yes, please provide physical address (include directions), householder’s name and contact number

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

____________________________  ____________________________

____________________________  ____________________________
Within the past 14 days have you, or any person listed above:

1. Been diagnosed with Coronavirus disease (COVID-19)? Yes ☐ No ☐
2. Had close contact with anyone diagnosed with COVID-19? Yes ☐ No ☐
3. Provided direct care for COVID-19 patients? Yes ☐ No ☐
4. Visited any patient having COVID-19? Yes ☐ No ☐
5. Worked/stayed in a closed environment with a COVID-19 patient? Yes ☐ No ☐
6. Lived in the same household as a COVID-19 patient? Yes ☐ No ☐
7. Experienced any of the following symptoms (check all reported symptoms)
   ☐ Fever/Chills ☐ Cough ☐ Sore Throat
   ☐ Difficulty breathing ☐ Runny nose ☐ Loss of smell, loss of taste
8. Visited or worked at a hospital or other healthcare facility?
9. Medical History:
   ☐ Respiratory Disease ☐ Diabetes
   ☐ Hypertension ☐ Immune Diseases

Please specify: ________________________________________________________________
_____________________________________________________________________________

10. Surgical History _____________________________________________________________
    ___________________________________________________________________________

11. Are you on any medication? (List) ______________________________________________
    ___________________________________________________________________________

Anyone travelling to Saint Lucia from a country listed by WHO as having active cases 30 days prior to travel will be required to quarantine according to the directive of the state.

I, _________________________________________________, hereby declare that the above information is correct.

_________________________    _________________________
Signature       Date