



## MINISTRY OF HEALTH AND WELLNESS HEALTH SCREENING QUESTIONNAIRE

Please print and complete on the day of arrival prior to arrival in Saint Lucia.

Name as shown on passport \_\_\_\_\_

Passport No. \_\_\_\_\_

Home Address \_\_\_\_\_

Hotel Name/Intended Address in Saint Lucia \_\_\_\_\_

**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 and who is not fully vaccinated will be required to quarantine according to the directive of the state.

I, \_\_\_\_\_, hereby declare that the above information is correct.

\_\_\_\_\_

Signature

\_\_\_\_\_

Date