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 St. 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), household’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 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 health care facility? Yes [ ] No [ ]
9. Medical History: [ ] Respiratory Disease  [ ] Diabetes
   [ ] Hypertension  [ ] Immune Diseases
   Please specify: ________________________________________________

10. Surgical History: ____________________________________________

11. Are you on any medication? (List) ________________________________________________

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