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