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