MINISTRY OF HEALTH, WELLNESS AND THE ENVIRONMENT
HEALTH SCREENING QUESTIONNAIRE

(to be completed by all adult passengers prior to disembarkation)

Airline: _____ Flight No.: _____

Name as shown in the passport: _____

Date of Birth: _____ Age *(at last birthday)*: _____

Email address:_____Contact number: _____

Address (overseas): _____

Intended address in Antigua:_____

Names and date of birth of all children travelling with you under 18 years old:

_____ _____

_____ _____

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 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

□ Runny nose □ Shortness of breath

Any person who answers yes to any of these questions or have any of the above symptoms will be placed in quarantine or isolation for up to 14 days.

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

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Signature **Date**