



MINISTRY OF HEALTH AND WELLNESS

HEALTH SCREENING QUESTIONNAIRE

(to be completed by all adult passengers prior to disembarkation if the pre-arrival registration has not been completed online)

Name as shown on the passport _____

Passport No. _____

Home Address _____

Intended address in Saint 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), 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
 Visited or worked at a hospital or other healthcare facility?

8. Medical History _____

9. Surgical History _____

10. 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 will be required to quarantine according to the directive of the state

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

Signature

Date