Pre-Departure Health Screening Questionnaire

Full Name

Date of Birth

Contact Number

Email Address

Have you experienced any of the following symptoms in the last 14 days?

- [ ] Fever
- [ ] Cough
- [ ] Shortness of Breath
- [ ] Loss of Taste or Smell
- [ ] Sore Throat
- [ ] None of the Above

Have you been in close contact with a confirmed case of infectious disease in the last 14 days?

Do you have any chronic medical conditions? If yes, please specify.

Are you currently taking any medications?

Have you received any vaccinations in the past 30 days?

Additional Information