

Cruise Ship Health Declaration Application Form

Full Name

Date of Birth

Gender

Passport Number

Nationality

Cabin Number

Email Address

Phone Number

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

☐

Fever

☐

Cough

☐

Shortness of Breath

☐

Sore Throat

Other symptoms (please specify)

Have you been in contact with a confirmed COVID-19 case in the last 14 days?

Have you travelled to any country with known outbreaks in past 14 days?

If yes, specify country/countries visited

Pre-existing Medical Conditions

Current Medications

Remarks / Additional Information

☐

I hereby declare that the information given above is true and correct to the best of my knowledge.