International Travel Health Declaration Form

Personal Information

Full Name

Passport Number

Nationality

Date of Birth

Email Address

Phone Number

Travel Information

Flight Number

Departure Country

Arrival Country

Date of Arrival

Address Abroad

Health Information

Have you experienced any of the following symptoms in the last 14 days? (check all that apply)

- [ ] Fever
- [ ] Cough
- [ ] Shortness of Breath
- [ ] Sore Throat
- [ ] None

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

Are you fully vaccinated against COVID-19?

Countries visited in the last 21 days

Declaration

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

Date

Signature