TRAVELER HEALTH DECLARATION FOR PRIMARY EXIT SCREENING

version 28 February 2022

Each traveler needs a separate form. Date:_____

Last (family) name: _____ First (given) name: _____ Sex: Male ☐ Female ☐

Citizenship:_____ Country of residence: _____ Birth date: ___ /___ / ___ (Day/Month/Year)

Affiliation (circle): MIL / CIV / CTR / DEP / OTHER Service (circle): AF / ARMY / NAVY / MC / CG DoD ID#_____

Flight number:_____ Date of destination arrival: ___ /___ / ___ (Day/Month/Year) Seat number on plane:_____

Final destination address:_____City: _____

State/Province: _____Country: _____E-mail address: _____

Do you have a mobile phone? Yes ☐ No ☐ Mobile number:_____

DO YOU HAVE or HAVE YOU RECENTLY EXPERIENCED (within the past 10 days) any of the following symptoms ? (Answer All of the Following):

- Fever or Chills..... YES ____ NO____
- Cough..... YES ____ NO____
- Shortness of Breath or Difficulty Breathing..... YES ____ NO____
- Fatigue..... YES ____ NO____
- Muscle or Body Aches..... YES ____ NO____
- Headache..... YES ____ NO____
- Loss of Smell or Taste..... YES ____ NO____
- Sore Throat..... YES ____ NO____
- Congestion or Runny Nose..... YES ____ NO____
- Nausea or Vomiting..... YES ____ NO____
- Diarrhea..... YES ____ NO____

Are any symptoms answered "Yes?" YES ___ NO___

1. Have you tested **positive** for COVID-19 within the last 10 days? **YES ___ NO___**
2. Have you been tested for COVID-19 but have not received the results? **YES ___ NO___**
3. Have you had contact with a person **suspected or known to be infected** with COVID-19 within the last 10 days? **YES ___ NO___**

I certify that I have answered these questions truthfully:

_____ _____

Passenger Signature or Authorized Sponsor Date

****SCREENING STAFF WILL COMPLETE SECTIONS BELOW AND ON NEXT PAGE****

Visible signs of illness: **Yes** ☐ **No** ☐

If passenger marked "YES" to ANY primary screening question or if they look ill , mark "Referred for secondary screening."

☐ Cleared for travel ☐ Referred for secondary screening

_____

Screener (must legibly print name and rank [if applicable], sign and date):

TRAVELER COVID-19 TEST EXEMPTION DOCUMENT VALIDATION

SCREENING STAFF WILL VALIDATE THE FOLLOWING SECTIONS--AS APPLICABLE

☐ **Yes** ☐ **No** 1. PROOF OF NEGATIVE COVID-19 TEST:

Date/Time documented on test:_____

Name/Type of test documented:_____

☐ **Yes** ☐ **No** 2. MEDICAL CLEARANCE LETTER (FOR COVID-19 RECOVERY WITHIN 90 DAYS)

Date of positive COVID-19 test:_____

☐ **Yes** ☐ **No** 3. COVID-19 TEST WAIVER

☐ **Yes** ☐ **No** 4. FULLY VACCINATED: **2 WEEKS POST-COMPLETION OF COVID-19 VACCINATION SERIES**

(SERIES COMPLETION = 2 DOSES PFIZER/MODERNA OR 1 DOSE J&J/JANSSEN ADMINISTERED)

Date of Series Completion_____

Date of COVID-19 Booster_____

_____

Screener (must legibly print name and rank [if applicable], sign and date):