TRAVELER HEALTH DECLARATION FOR PRIMARY EXIT SCREENING

version 03 June 2022 (TCM)

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: ☐ PCR / ☐ ANTIGEN _____

☐ 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):**