# DOMESTIC HEALTH TRAVEL CARD

DATE: MM/DD/YYYY:_____NIB NUMBER/DRIVER'S LICENSE NO:_____

TRAVELER NAME: SURNAME:_____FIRST:_____

PHONE NO:_____ EMAIL:_____ SEX ☐ M ☐ F AGE:_____

DATE OF BIRTH: MM/DD/YYYY: _____AIRLINE/SEA VESSEL: _____

ISLAND VISITING:_____

ADDRESS ON ISLAND: _____CONTACT ON ISLAND: _____

## DO YOU HAVE ANY OF THE FOLLOWING SIGNS AND SYMPTOMS? (CHECK ALL THAT APPLY)

☐ Fever ☐ Cough ☐ Sore throat ☐ Shortness of breath ☐ Loss of taste ☐ Loss of smell
☐ Diarrhea ☐ Loss of appetite ☐ Fatigue ☐ Muscle pain

| | | | |
|---|---|---|---|
| 1. Have you had close contact with a person who is under investigation for COVID-19? | ☐ Y | ☐ N | ☐ UNKNOWN |
| 2. Have you had known contact with a laboratory-confirmed COVID-19 case? | ☐ Y | ☐ N | ☐ UNKNOWN |
| 3. Have you had a positive COVID-19 test? | ☐ Y | ☐ N | ☐ UNKNOWN |
| 4. Have you been in quarantine for COVID-19? | ☐ Y | ☐ N | ☐ UNKNOWN |