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| **Medical Clearance Health Documentation Check in Form *MoH 001/20*** |
| **Name (First, Last):**…………………………………………………………………………………………. |
| **Passport Number:** **….………………………………..** | **Sex :**  **Male Female**  | **Date of birth:** **………... / …..……./ 20……..**  |
| **Phone Number: …………………………………..** | **Email: …………………………………………………** | **Samoan Resident:** Yes No  |
| **Have you been Vaccinated with a COVID-19 Vaccine** | Yes No (If Yes Please provide proof of vaccination and fill in information below)  |
| Name of Vaccine: |
|  | Date of; 1st Dose ……../……../ 2021: 2nd Dose ……./……./2021Clinic or Provider Name: |
| **Any History of Respiratory Problems or Chronic Illness: (Please Circle)** | Hypertension / Diabetes Mellitus / Heart Disease / Asthma /COPD….. |
| **Declaration:***(Penalties will be imposed for false declarations)* | I *………………………………………………………………...(insert name)* declare that all information provided in this Form is true and accurate and I solemnly declare that I have not been diagnosed and/or infected with COVID 19 with in the past six (6) months**\*\***.Signature of Passenger …………………………………………………………………*Witnessed by the Medical Officer/Doctor……………………………………………………..(as per the Doctor’s details provided below)* |
| **COVID19 Related Signs and Symptoms****Yes ( √) No (X)** | Fever/Chills |  | Cough / Shortness of breath |  | Loss of taste or smell |  | Generalized Body Weakness |  | Diarrhea/Nausea/Vomiting |  |
| **Measured Vitals:** | **Other Conditions/Symptoms/Notes:** |
| Temperature: | **°C** |  |  |
| Blood Pressure: | **mmHg** |
| Oxygen Saturation: | **%** |
| Respiratory Rate: | **bpm** |
| Pulse:  | **bpm** |  |
| **COVID19 PCR Laboratory Test (Please Attach Copy of Lab Result or an Email informing of Result; Dated and Verified.)** |
| **Name of Laboratory/Site Lab Testing Facility (COVID19 Testing):** **…………………………………………………………………………………………………….** | **Test Reference Number:**…………………………………………… |
| **Address:** **……………………………………………………………………………………………………….** |
| **Specimen:** | **Nasopharyngeal COVID-19 swab OR****Oral pharyngeal COVID19 swab** | **Result as Reported;** **Positive Negative** |
| **Date:** | **Collected;****………... / …..……./ 20………** | **Reported;****…….….. / …..……./ 20……….** |
| **Doctor and Clinic Details** |
| **Name of Doctor\*\*(PRINT): …………………………………………………………………………** ***(Registered General Practitioner; Respiratory Clinician or Attending Physician)*****Address (PRINT) : ……………………………………………………………………………………..****Email (PRINT): ………………………………………………………………………………………....****Signature:……………………………………………………… Registration Number: ………………………** |  |
| **Clinic Stamp and Date …….……….……….** |