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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 ……./……./2021  Clinic 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 …….……….……….** | | | |