

UNITED STATES

TRAVELER HEALTH DECLARATION FOR EXIT SCREENING

Providing the following information to the Centers for Disease Control and Prevention is authorized under Title 42 Code of Federal Regulations Section 71.20, and is being collected as part of the public health response to 2019 Novel Coronavirus (COVID-2019). The information will be used by U.S. public health authorities and other international, federal, state, or local agencies for public health purposes.

Each traveler needs a separate form.

Family name: First (given) names:

Citizenship:..... Country of residence:

Birth date: ___ / ___ / ___ (Day/Month/Year) Sex: Male [] Female []

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

Final destination US address:

.....City:

State/Province: Country:E-mail address:

Do you have a US mobile phone? Yes [] No [] US mobile number:

TODAY, OR IN THE PAST 24 HOURS, HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS?

- Fever (100.4° F / 38° C or higher), felt feverish, or had chills?
Cough?
Difficulty breathing?

Table with 2 columns: YES, NO and 3 rows for symptoms.

IN THE PAST 14 DAYS

1. Have you visited, worked in or been hospitalized in any health care facility in Italy? YES ___ NO ___

a) City where facility is located:

b) Date of last visit or discharge: ___/___/___ (Day/Month/Year)

2. Have you had contact with a person known to be infected with the Novel Coronavirus? YES ___ NO ___

4. If yes to # 3

a) What was your relationship to the person(s) (friend, colleague, family member, spouse)?

.....

b) Did you have close contact (within 6 feet/2 meters)? YES ___ NO ___

c) Did you provide care to the person? YES ___ NO ___

i. If yes, where? Check one: Home [] Health care facility []

TO BE COMPLETED BY SCREENING STAFF

Temp [] Visible signs of illness: [] Yes [] No [] Screener: