American Samoa Department of Health
COVID 19 Health Clearance Form

Public Health
Prevent. Promote. Protect.
American Samoa
Department of Health

This form is to be filled and signed by a U.S licensed N.P, P.A-C, or Physician and submitted as soon as possible. A Negative SARS-CoV-2 lab test must be submitted no later than 72 hours prior to arrival at the ASDOH Hawaii Quarantine Site. All travelers will be quarantined for ongoing medical evaluation and serial Covid-19 testing. You are required to complete a ten (10) days quarantine in our ASDOH Hawaii Quarantine Site, endure 6hrs flight to American Samoa with an additional fourteen (14) days quarantine at the ASDOH Quarantine Site on Island. Prior negative test results or quarantine does not exempt you from our quarantine procedures.

Have you ever tested positive for COVID19? YES ☐ NO ☐

If yes, provide 2 post infection Negative COVID19 test results, indicating you have been cleared of SARS-CoV-2 virus infection to dohcovid19clearance@doh.as. You will not be allowed entry into ASDOH Hawaii Quarantine Site until 28 days from the date of the second NEGATIVE COVID19 test, indicating that you have been cleared of the virus.

TRAVELER'S INFORMATION & DEMOGRAPHICS

Traveler's name (First, Last) _____ **Hospital#** _____

Date of Birth date ___/___/___ **Sex:** ☐ F ☐ M ☐ Other **Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ Samoan ☐ Tongan ☐ Fijian ☐ Filipino ☐ Asian ☐ White ☐ Black ☐ Other_____

Phone _____ **Email** _____ **Village of Residence:** _____

City/State/Zip/County _____ **American Samoa resident** ☐ Yes ☐ No

Medical Information:
Do you require Renal Dialysis?: ☐ YES ☐ NO

Do you have any disabilities or special needs? ☐ YES ☐ NO If "**YES**" , PLEASE SPECIFY ANY SPECIAL NEEDS WE MAY NEED TO ACCOMMODATE DURING QUARANTINE: _____

PLEASE SPECIFY ANY ALLERGIES TO FOOD OR MEDICATION:_____

PLEASE SPECIFY ANY DIETARY RESTRICTIONS:_____

SECTION TO BE FILLED BY A MEDICAL OFFICER

Height _____ (cm) Weight _____(kg) Temperature _____(oC) Respiratory rate: _____/min RBS: _____

Pulse _____(Bpm) Regular or Irregular (circle one) Blood pressure _____SYS) / _____ (DIA) Oxygen saturation _____%

COVID19 Vaccination: Have you received the COVID19 Vaccine? ☐ YES ☐ NO

If "YES, Please specify: **Manufacturer:**_____ 1st Dose date: _____ 2nd Dose date:_____

CLINICAL FEATURES

Y	N	Unk	
☐	☐	☐	**Any fever, subjective or measured**
☐	☐	☐	Chills or rigors
☐	☐	☐	Headache
☐	☐	☐	Myalgia (muscle aches or pains)
☐	☐	☐	Pharyngitis (sore throat)
☐	☐	☐	Sinus congestion
☐	☐	☐	**Cough**
☐	☐	☐	Productive cough Onset date ___/___/___
☐	☐	☐	Dry cough Onset date ___/___/___
☐	☐	☐	**Dyspnea (shortness of breath)**
☐	☐	☐	**Pneumonia**
☐	☐	☐	Nausea / Vomiting
☐	☐	☐	Diarrhea
☐	☐	☐	Abdominal pain or cramps
☐	☐	☐	Sudden loss of taste or smell
☐	☐	☐	Other symptoms _____

Predisposing Conditions

Y	N	Unk	
☐	☐	☐	Current tobacco smoker
☐	☐	☐	Diabetes mellitus
☐	☐	☐	Chemotherapy
☐	☐	☐	Steroid therapy
☐	☐	☐	Cancer diagnosis or treatment in 12 months prior to
☐	☐	☐	onset Organ transplant
☐	☐	☐	Immunosuppressive therapy, condition or disease
☐	☐	☐	Chronic heart disease
☐	☐	☐	Asthma/reactive airway disease
☐	☐	☐	Chronic lung disease (e.g., COPD, emphysema)
☐	☐	☐	Chronic liver disease
☐	☐	☐	Chronic kidney disease
☐	☐	☐	Hemoglobinopathy (e.g., sickle cell disease)
☐	☐	☐	Current prescription or treatment
☐	☐	☐	Hemodialysis at time of onset
☐	☐	☐	Other underlying medical conditions _____

Does the traveler, listed above, need to attend any medical follow-up appointments within the next 12 months? ☐ Yes ☐ No

☐ I certify that all information above is correct and the person whose name is mentioned in the "Traveler's Information & Demographics" section above is Medically Stable and Fit for travel and quarantine (up to 28 days).

_____ Print Name of Medical Official & Titile

_____ Signature & Date