



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: <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Other	Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino
Race: <input type="checkbox"/> Samoan <input type="checkbox"/> Tongan <input type="checkbox"/> Fijian <input type="checkbox"/> Filipino <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Other _____		
Phone _____	Email _____	Village of Residence: _____
City/State/Zip/County _____		American Samoa resident <input type="checkbox"/> Yes <input type="checkbox"/> 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	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Any fever, subjective or measured
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chills or rigors
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headache
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Myalgia (muscle aches or pains)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pharyngitis (sore throat)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus congestion
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cough
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Productive cough Onset date ___/___/___
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry cough Onset date ___/___/___
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dyspnea (shortness of breath)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea / Vomiting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain or cramps
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sudden loss of taste or smell
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other symptoms _____

Predisposing Conditions

Y	N	Unk	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Current tobacco smoker
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes mellitus
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Steroid therapy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer diagnosis or treatment in 12 months prior to onset Organ transplant
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Immunosuppressive therapy, condition or disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic heart disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma/reactive airway disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic lung disease (e.g., COPD, emphysema)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic liver disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic kidney disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemoglobinopathy (e.g., sickle cell disease)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Current prescription or treatment
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemodialysis at time of onset
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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 & Title

Signature & Date