American Samoa Government
TRAVEL HEALTH DECLARATION

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

Date this form was completed: ____ / ____ / ____ (MM/DD/YYYY)

Providing the following information to the Centers for Disease Control and Prevention is required under the ASCA §§ 13.0213 and 13.0227, and is being collected as part of the public health response to a new coronavirus identified in China. The information will be used by the US public health authorities and other international, federal, state, or local agencies for public health purposes.

In the past 2 weeks, have you been to a country with active transmission of COVID 19? ☐ Yes ☐ No

Please list all Countries and City you have traveled to in the past 2 weeks: _____

If traveling from the United States, what is the City and State of your Original departure: _____

Have you ever tested "POSITIVE" for COVID19? ☐ Yes ☐ No If "Yes", please provide proof of two "NEGATIVE" COVID19 Tests to ASDOH

Last Name:	**First Name:**		
Name of Village or Hotel:	**Date of birth:** / / (mm/dd/yyyy)	**Sex:** ☐ Male ☐ Female	
Date of Arrival: / / (mm/dd/yyyy)	**Airline:**	**Flight No:**	**Seat #:**
Email:	**Telephone No:**		

Do you currently have any of the following symptoms?

Fever (100.4 ˚F / 38 ˚C or Higher), felt feverish, or had chills? ☐YES ☐NO	Sore Throat? ☐ YES ☐ NO	Cough? ☐ YES ☐ NO
Difficulty Breathing? ☐YES ☐NO	Fatigue? ☐YES ☐NO	New loss of smell or taste? ☐ YES ☐ NO
Congestion or runny nose? ☐YES ☐NO	Muscles or body aches? ☐ YES ☐ NO	Nausea or Vomiting? ☐ YES ☐ NO

Medical Information:

Do you require Renal Dialysis?: ☐YES ☐NO If "**YES**", date of last Dialysis treatment: ___ / ___ / ___ (mm/dd/yyyy)

Do you have any disabilities and/or special needs? ☐ Yes ☐ No

IF "**YES**" PLEASE LIST ANY SPECIAL NEEDS WE MAY NEED TO ACCOMMODATE DURING QUARANTINE:_____

PLEASE SPECIFY ANY ALLERGIES TO FOOD OR MEDICATION:_____

PLEASE SPECIFY ANY DIETARY RESTRICTIONS:_____

Do you have any Medical Conditions

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

To be completed by ASDOH Medical Staff

Measured Temperature: _____

ASDOH Staff Initials and Signature

_____

Health Official's Comments:

Other Comments: