**Pre-departure Information on persons being repatriated**

**Demographics:**

Name

Age

Gender

Address: Country \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Living in the country since when

Countries visited in last 28 days:

Intended date of arrival in Solomon Islands:

Occupation:

Accompanied by family:

Details of family members:

|  |  |  |
| --- | --- | --- |
| **Name** | **Age** | **Gender** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Living arrangement in the country from where being repatriated:**

How were you living in the country from where you are being repatriated?

Alone/ with family/ with colleagues or co-workers (dormitory or sharing rooms or bathrooms)

If living with colleagues of coworkers provide details below

|  |  |  |
| --- | --- | --- |
| **Name** | **If the person is being repatriated** | **Living with the person since when** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Public Health measures:**

Were you in quarantine in the country from where you are being repatriated:

Yes: Home-based/ institutional based

If yes: Did you share accommodation with someone?

If yes Name of the person and if that person is being repatriated

Is it mandatory for you to wear masks while going out of your home?

**Testing and history of contact for COVID-19:**

Were you ever tested for COVID-19 Yes/ No

If you were ever tested provide dates of the tests

Date 1: Date 2: Date 3:

Were you ever tested positive for COVID-19 Yes/ No

If Yes Date of positive COVID-19 test

Did you in the past 14 days come in contact with a person suspected or confirmed with COVID-19

Did you in the past 14 days come in contact with a person with respiratory symptoms such as fever and cough

Did you in the past 14 days visit any health care facility

**Symptoms:**

Are you currently having any of the following symptoms:

□ History of fever / chills □ Shortness of breath □ Pain (check all that apply) □ General weakness □ Diarrhoea ( ) Muscular ( ) Chest

 □ Cough □ Nausea/vomiting ( ) Abdominal ( ) Joint

□ Sore throat □ Headache □ Runny nose □ Irritability/Confusion □ Conjunctivitis:

□ Other, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are having any of the above symptoms: Please consult your doctor and DO NOT board the flight

**Special Needs assessment:**

Do you have any special needs in terms of mobility?

Are you on regular medication for some diseases and will require medication during the period of quarantine?

Do you have any special dietary requirements?

Do you have any allergy?

Are you pregnant: # of months

Are your any vaccination due?

**For Official Use only DO NOT COMPLETE**

Flight schedule and stoppage:

Seat number on-board

Allotment of quarantine place:

Special needs:

Testing for COVID-19 schedule: