

Questionnaire for people coming to Solomon Islands

To be completed by each traveler and sent 5 days prior to intended date of arrival in Solomon Islands (SI) to: **NHEOC_REPAT@moh.gov.sb**

While sending the files electronically, the name of the file should include name of the traveler.

Please ensure that the size of the email does not exceed 8 MB otherwise it will be rejected by the SI Government server.

Demographics

Please complete the following details:

Name (as in your passport)		
Passport Number		
Citizenship		
Date of Birth		Age:
Gender (please tick)	Male <input type="checkbox"/>	Female <input type="checkbox"/>
FLIGHT DATE (Provide proposed itinerary)		

Contact Details

Please provide information on how to contact:

Email	
Mobile phone: current location and in Solomon Islands	
Current Address (where you are presently living) incl CITY	
City of intended stay in Solomon Islands	

Travel History

1	Countries visited in last 28 days including transit while enroute to Solomon Islands	Please list:
2	Did you move from another province/ state in country you are living in to the port of departure?	Date of move:

Living Arrangements in the Country you are repatriating from

1	Are you currently quarantined or self-isolating where you are presently residing? If Yes, provide the details (Date since quarantined)	Yes <input type="checkbox"/>	No <input type="checkbox"/> Date:
----------	--	------------------------------	--

Repatriation Plans

Do you plan to be repatriated with family or work colleagues? Provide details of family members:

Name (as in their passport)	Age	Gender

Contact with a COVID-19 or Monkeypox Patient

Please complete the following questions:

1	Did you in the past 14-days come in contact with a person suspected or confirmed with COVID-19?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2	Did you in the past 14-days come in contact with a person with respiratory symptoms such as fever and cough, sore throat, runny nose, sore muscles, loss of taste or loss of smell?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3	Did you in the past 21 days come in contact with confirmed case of Monkeypox?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

COVID-19 and Measles Vaccination History

Section A: COVID-19 Vaccination

1. Name and Date of first vaccination	
2. City & country administered	
1. Name and Date of second vaccination	
2. City & country administered	
1. Name and Date of Third vaccination/ Booster	
2. City & country administered	

Section B: Measles Vaccination

1	Have you been vaccinated against Measles?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2	Date of measles vaccination; Submit a copy of measles vaccination	Date:	

COVID-19 Testing

1	Were you ever tested for COVID-19?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2,	Were you ever tested positive for COVID-19, if yes provide the date	Yes <input type="checkbox"/>	No <input type="checkbox"/>
		Date when tested positive:	

Please provide dates and results of COVID-19 tests in past 1 week

Test Date	Result	
1.	Positive <input type="checkbox"/>	Negative <input type="checkbox"/>
2.	Positive <input type="checkbox"/>	Negative <input type="checkbox"/>
3.	Positive <input type="checkbox"/>	Negative <input type="checkbox"/>
4.	Positive <input type="checkbox"/>	Negative <input type="checkbox"/>

Add more lines if needed

Are you having any of the following symptoms?

Symptoms: please tick if you have any of the following symptoms		
Fever/chills <input type="checkbox"/>	General weakness/fatigue <input type="checkbox"/>	Loss of taste <input type="checkbox"/>
Cough <input type="checkbox"/>	Shortness of breath <input type="checkbox"/>	Loss of smell <input type="checkbox"/>
Headache <input type="checkbox"/>	Muscle weakness <input type="checkbox"/>	Sore throat <input type="checkbox"/>
Runny nose <input type="checkbox"/>	Anorexia/Nausea/Vomiting <input type="checkbox"/>	Diarrhoea <input type="checkbox"/>
Conjunctivitis <input type="checkbox"/>	Irritability/Confusion <input type="checkbox"/>	Other, specify:
Body Rash	Vesicles on body	Swelling of lymph nodes
<p>If you are having any of the above symptoms: Please consult your doctor and DO NOT board the flight</p>		