Questionnaire for people coming to Solomon Islands

To be completed by each traveler and sent 5 days prior to intended date of travel to:
NHEOC_REPAT@moh.gov.sb

While sending the files electronically, the name of the file be the name of the traveler)

Demographics

Please complete the following details:

Name (as in your passport)		
Passport Number		
Citizenship		
Date of Birth		**Age:**
Gender (please tick)	Male ☐	Female ☐
VISA Issues	Clear to fly	Visa clearance in process / Visa not cleared yet
Any other issues		

Contact Details

Please provide information on how to contact:

Email	
Mobile phone: current location and Solomon Islands	
Current Address (where you are presently living)	

Living Arrangements in the Country you are repatriating from

1 A	**Are you currently quarantined where you are presently residing? If yes, provide date when you moved into the hotel/place?**	**Yes** ☐ **No** ☐ **Date:**
1B	**Are you presently quarantined in your own accommodation?** **If Yes, provide the details** **Date since quarantined** **Is the quarantine place a hotel or home or others please specify**	**Yes** ☐ **No** ☐ **Date:** **Hotel** ☐ **Home** ☐ **Others (Specify)**
2	**If you are quarantined, are you sharing the room with someone:**	**Yes** ☐ **No** ☐

3	**If you are sharing the room with some, provide name of the person as written in their passport**	**Name:** **Name:** **Name:** **Name:** **Name:**
4	**If you are living in your own accommodation, provide names of the persons you are living with as it is written in their passports**	**Name:** **Name:** **Name:** **Name:** **Name:**

Travel History

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

Quarantine History

1	**Have you been involved in the breach of quarantine regulations in country you are living in?** If yes, please give details:	**Yes** ☐ **No** ☐
2	**Have you come across any instance where you observed that someone who is being repatriated with you breached the quarantine regulations?** Examples: Visiting another person's room; leaving the quarantine facility; not social distancing; not wearing PPE such as a mask If yes, please give details:	**Yes** ☐ **No** ☐

Repatriation Plans

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

Name (as in their passport)	**Age**	**Gender**	**Passport Number**

COVID-19 Contact

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** ☐	**No** ☐
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** ☐	**No** ☐
3	**Did you in the past 14-days visit any health care facility? Reason?**	**Yes** ☐	**No** ☐

COVID-19 Vaccination History

Name of Vaccination	
1. Date of first vaccination 2. City & country administered	
1. Date of second vaccination 2. City & country administered	

COVID-19 Testing

1	**Were you ever tested for COVID-19?**	**Yes** ☐	**No** ☐

If yes, please provide dates and results of COVID-19 tests

Test Date	Results	
1.	**Positive** ☐	**Negative** ☐
2.	**Positive** ☐	**Negative** ☐
3.	**Positive** ☐	**Negative** ☐
4.	**Positive** ☐	**Negative** ☐

Add more lines if needed

Medical History

1	**Do you suffer from any chronic conditions such as heart or respiratory disease; diabetes; hypertension etc.**	**Yes** ☐ **No** ☐ **If yes, please list:**		
2	**Do you have any special needs in terms of mobility?**	**Yes** ☐ **No** ☐ **If yes, please list:**		
3	**Symptoms:** please tick if you have any of the following symptoms			
	Fever/chills ☐	General weakness/fatigue ☐	Loss of taste ☐	
	Cough ☐	Shortness of breath ☐	Loss of smell ☐	
	Headache ☐	Muscle weakness ☐	Sore throat ☐	
	Runny nose ☐	Anorexia/Nausea/Vomiting ☐	Diarrhoea ☐	
	Conjunctivitis ☐	Irritability/Confusion ☐	**Other, specify:**	
If you are having any of the above symptoms: Please consult your doctor and DO NOT board the flight				

Special Needs Assessment

1	**Are you on regular medication for some diseases?** If yes, please list:	**Yes** ☐	**No** ☐
2	**Will require medication during the period of quarantine?** If yes, please list:	**Yes** ☐	**No** ☐
3	**Do you have any special dietary requirements?** If yes, please list:	**Yes** ☐	**No** ☐

4	**Do you have any allergy?** If yes, please list:	**Yes** ☐	**No** ☐
5	**Are you pregnant?** Number of months pregnant: Expected Date of Delivery:	**Yes** ☐	**No** ☐
6	**Are any of your vaccination due?** If yes, please list:	**Yes** ☐	**No** ☐

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: