Ministry of health

REPUBLIC OF ZAMBIA

## TRAVELER HEALTH QUESTIONNAIRE

### Traveler's details

| | |
|---|---|
| Full names* | |
| Age | Sex |
| Country of original departure | |
| Passport number | |
| Occupation* | |
| Flight/Vessel number/name* | |
| Seat number* | |
| Countries visited in the last 30 days* | |
| Reasons for visiting Zambia | |
| Duration of stay | |
| Contact Number in Zambia: | Alternative Contact Number: |
| E-mail: | Address in Zambia* |

### Health Information

Do you have any of the following symptoms? (please tick all that apply)

- ☐ Fever
- ☐ Abdominal pain
- ☐ Rash
- ☐ Vomiting
- ☐ Headache
- ☐ Muscle pain
- ☐ Diarrhea
- ☐ Bruising or bleeding
- ☐ Cough
- ☐ Sore throat
- ☐ Breathing difficulties
- ☐ Shortness of breath
- ☐ Jaundice (yellowing of eyes and skin)

Temperature reading …….

The traveler hereby certifies that the information he/she has provided is true and that he/she subjects himself/herself to further assessment at a designated health facility (if he/she has any signs and symptoms listed above). If The traveler does not have the symptoms listed above, they must be followed up either by telephone/mobile phone or physically at a place of destination in Zambia for a period of 14– 21 days. In an event that you develop any of the above symptoms within 14– 21 days, please contact the nearest health facility. Signature of traveler: Date:

## FOR OFFICE USEONLY

### Port Health Official details

| | | |
|---|---|---|
| Name: | Province: | Point of entry: |
| Telephone of Institution: | Mobile Number: | E-mail: |

### Health facility details if traveler referred

| | | |
|---|---|---|
| Name of Health Facility: | Examining clinician: | Tel no. of examining clinician: |
| GENERAL COMMENTS: | | |