# Health Care Surveillance for Embarking Guests

Please take your time and answer the following questionnaire:

Name: (*please print*) _____

Suite Number: _____ Ship: _____

Date: _____ Port: _____

Names of children under the age of 18 travelling with you:

1. _____ 2. _____
3. _____ 4. _____

***What symptoms do you have or had in the last fourteen (14) days?***

| Symptoms | Yes | No | Onset time |
|---|---|---|---|
| 1. Do you have or have you had a fever (100.4F/38C or higher), feel feverish, or have chills, a cough or difficulty breathing? | | | |
| 2. Have you travelled yourself **OR** have you been in contact with anyone who has travelled from, to or through China, Hong Kong, Macau, South Korea, Iran or any municipality in Italy subject to lockdown as designated by the Ministry of Foreign Affairs in the past 14 days? | | | |
| 3. Have you had close contact with, or helped care for, anyone suspected or diagnosed as having Covid-19, or who is currently subject to health monitoring for possible exposure to Covid-19? | | | |
| If you answered **YES** to any of the above, please provide additional information. | | | |

All persons boarding the vessel may be subjected to temperature reading via a thermal, oral or tympanic temperature scanner.

If you answered "YES" you will be assessed free of charge by a member of the shipboard medical staff. The information in this questionnaire may be reported to the relevant public health authorities.

***What symptoms do you have or had in the last fourteen (14) days?***

| Symptoms | Yes | No | Onset Time |
|---|---|---|---|
| 4. Vomiting | | | |
| 5. Diarrhea | | | |
| 6. Bloody Stools | | | |
| 7. Nausea | | | |
| 8. Muscle/Joint Ache | | | |
| 9. Abdominal Cramps | | | |

- Did you stay overnight or longer in the boarding port before you joined the ship? YES NO
  If yes, where did you stay? _____
- How many glasses of unbottled water/ other beverages did you drink a day? (None, 1–3, 4–6, 7–9, 10 or more)
- How many servings of beverages containing ice did you drink a day? (None, 1–3, 4–6, 7–9, 10 or more)

_____
Signature

Medical Assessment: (Use Universal PPE)
Temperature: _____ Other _____
Comments: _____
Signature: _____ Date: _____