



### Medical Clearance Health Documentation Check in Form *MoH 001/20*

Name (First, Last): .....

Passport Number: ..... Sex : Male  Female  Date of birth: ..... / ..... / 20.....

Phone Number: ..... Email: ..... Samoan Resident: Yes  No

Have you been Vaccinated with a COVID-19 Vaccine Yes  No  (If Yes Please provide proof of vaccination and fill in information below)  
 Name of Vaccine: .....  
 Date of; 1<sup>st</sup> Dose ...../...../ 2021: 2<sup>nd</sup> Dose ...../...../2021  
 Clinic or Provider Name: .....

Any History of Respiratory Problems or Chronic Illness: (Please Circle) Hypertension / Diabetes Mellitus / Heart Disease / Asthma /COPD.....

**Declaration:** I .....(insert name) declare that all information provided in this Form is true and accurate and I solemnly declare that I have not been diagnosed and/or infected with COVID 19 with in the past six (6) months\*\*.  
 (Penalties will be imposed for false declarations)  
 Signature of Passenger .....  
 Witnessed by the Medical Officer/Doctor.....(as per the Doctor's details provided below)

<b>COVID19 Related Signs and Symptoms</b> Yes (✓) No (X)	Fever/ Chills	Cough / Shortness of breath	Loss of taste or smell	Generalized Body Weakness	Diarrhea/Nausea/Vomiting
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<b>Measured Vitals:</b>	<b>Other Conditions/Symptoms/Notes:</b>
Temperature: ..... °C	
Blood Pressure: ..... mmHg	
Oxygen Saturation: ..... %	
Respiratory Rate: ..... bpm	
Pulse: ..... bpm	

#### COVID19 PCR Laboratory Test (Please Attach Copy of Lab Result or an Email informing of Result; Dated and Verified.)

Name of Laboratory/Site Lab Testing Facility (COVID19 Testing): ..... Test Reference Number: .....

Address: .....

Specimen: Nasopharyngeal COVID-19 swab OR Oral pharyngeal COVID19 swab Result as Reported;  Positive  Negative

Date: Collected; ..... / ..... / 20..... Reported; ..... / ..... / 20.....

#### Doctor and Clinic Details

Name of Doctor\*\* (PRINT): .....  
 (Registered General Practitioner; Respiratory Clinician or Attending Physician)  
 Address (PRINT) : .....  
 Email (PRINT): .....  
 Signature:..... Registration Number: ..... Clinic Stamp and Date .....

**NOTE:** Medical Report and COVID19 Lab Test **MUST be Done within 72 hours** on Arrival at last port before travelling to Samoa. Copy of Lab Result must be verified and attached or an Email informing of Result – **Both are requirements for Boarding** and on Arrival.