Government of Samoa
Ministry of Health

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; 1st Dose ……/……/ 2021: 2nd Dose ……/……/2021 Clinic or Provider Name:
Any History of Respiratory Problems or Chronic Illness: (Please Circle)	Hypertension / Diabetes Mellitus / Heart Disease / Asthma /COPD…..

Declaration:

(Penalties will be imposed for false declarations)

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.

Signature of Passenger ……

Witnessed by the Medical Officer/Doctor……(as per the Doctor's details provided below)

COVID19 Related Signs and Symptoms Yes (√) No (X)	Fever/ Chills		Cough / Shortness of breath		Loss of taste or smell		Generalized Body Weakness		Diarrhea/Nausea/Vomiting	

Measured Vitals:	
Temperature:	°C
Blood Pressure:	mmHg
Oxygen Saturation:	%
Respiratory Rate:	bpm
Pulse:	bpm

Other Conditions/Symptoms/Notes:

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 ……