MEDICAL DECLARATION FORM

This is important document, your information is vital to allow health authorities contact you to prevent communicable diseases

- Full name (BLOCK LETTERS): ....
- Date of Birth: .... Gender: .... Nationality: ....
- Passport number or other legal document: ....

Travel information: Plane □ Ship □ Automobile □ Other (clarify): ....

Transportation No.:... Seat No.:...

Departure date: ..../......./...................... Immigation date: ..../......../...

Place of departure (province/country): ....

Place of destination (province/country): ....

In the past 14 days, have you been to any province/city/territory/country? If yes, where?: ....

Contact information in Viet Nam

- Staying address: ....
- Tel./Mob.: .... Email: ....

If you have any of the followings at present or during the past 14 days (until the date of entry/exit/transit)?

Symptoms	Yes	No	Symptoms	Yes	No
- Fever	[ ]	[ ]	- Vomiting	[ ]	[ ]
- Cough	[ ]	[ ]	- Diarrhea	[ ]	[ ]
- Difficulty of breathing	[ ]	[ ]	- Rash	[ ]	[ ]
- Sore throat	[ ]	[ ]	- Skin haemorrhage	[ ]	[ ]

List of vaccines or biologicals used: ....

History of exposure: During the last 14 days, did you:

- Visit any poultry farm/ living animal market/ slaughter house/ contact to animal	Yes [ ] No [ ]
- Care for a sick person of communicables diseases	Yes [ ] No [ ]

The information I have given is true, correct and complete. I understand failure to answer any question may have serious consequences.

Date: *Month:* *Year: 202...* **Signature of Passenger/Crew**