

The Republic of Namibia MINISTRY OF HEALTH AND SOCIAL SERVICES

HEALTH QUESTIONNAIRE FOR TOURISM REVIVAL INITIATIVE TRAVELERS

(This questionnaire must be co	mpleted by all incoming travellers prior to departure)
Expected date of Arrival:	
Flight No:	Seat No:
First Name:	
Surname:	
Phone Number:	
Email Address:	
	Age
Country of Departure, including	connection stops before this trip:
Envisaged Destination in Namib	ia (Please list all destinations, with name of town and hotel):

Intended length of stay in Namibia:		(Days)		
Within the past 14 days have you ever been to any of the COVID-19 affected country/area?				
Yes No				
If yes, which country/area? Pleas Within the past 14 days have you		or cared for someone w	ho has been diagnosed with COVID-	
Yes No				
Do you have any of the following (Tick as appropriate)	signs or symptoms?			
Symptoms	Yes	No	Unknown	
Fever				
Cough				
Chills or rigors				
Sore throat				
Shortness of breath				
Runny nose				
Headache				
Fatigue/feeling tired				
Loss of taste/smell				
Muscle pain				
Joint Pain				
Nausea				
Chest pain				
Other symptoms				
I	Pledge to ol	bey all the COVID-19 Hea	lth Regulations of the Republic	
of Namibia.				
Date:				
Signature				
Please go to the nearest Health	facility or call the toll-fr	ee number 0800100100,	should you experience any of	
the above-mentioned symptoms) .			