|  |
| --- |
| The Department of Defense follows the Centers for Disease Control’s lead for managing and monitoring the spread of the COVID-19 virus and other infectious diseases; and to mitigate the risk to U.S. military forces, additional measures have been authorized, to protect Service members, civilian employees, contract personnel, and family members.Below is a form to solicit additional health information from you so that Navy medical staff can evaluate your recent health and help to prevent the spread of contagious viruses to the crew of the ship.Please answer each of the questions on this form.***Please know:***-- The morning of your embark you will meet with a representative, who will review your responses and record your temperature, to ensure you’re not experiencing a fever before traveling to the ship.-- IF, any guest is experiencing an active fever, they will not be allowed to embark. DO NOT show up the morning of your embark, and 'hope for the best'.-- IF you have recent exposure to the COVID-19 virus, but are showing no symptoms the representative will make a recommendation to the Naval Surface Forces Chief of Staff about your participation. You will be informed directly by the PAO staff if your participation will be allowed.***-- Proof of vaccination will be required to participate on embarks conducted in 2021.*** |
| **#** | **Req.** |  | **Response** |
| 1 | **Y** | **Embark Date:**  | Calendar |
| 2 | **Y** | **Guest Last Name:** | (Narrative) |
| 3 | **Y** | **Guest First Name:** | (Narrative) |
| 4 | **Y** | **Embarking Ship:**  | (Narrative) |
| 5 | **Y** | **Have you completed a COVID-19 vaccination program at least 14 days prior to your embark?** | Yes, No |
| 6 | **Y** | If Yes, select date of first vaccination | Calendar |
| 7 | **Y** | If Yes, select vaccination type: | OPTIONS: Pfizer, Moderna, Johnson & Johnson |
| 8 | **Y** | If yes, Please list the Lot Number of the vaccination you received | (Narrative) |
| 9 | N | If Yes, Enter location / organization administering the vaccine | (Narrative) |
| 10 | N | If Yes, select date of second vaccination | Calendar |
| 11 | N | If yes, Please list the Lot Number of the vaccination you received | (Narrative) |
| 12 | N | If Yes, Enter location / organization administering the vaccine | (Narrative) |
| 13 | **Y** | **Have you received a 2020-2021 Season Flu Shot?** | Yes, No |
| 14 | Y | If Yes, select date of vaccination | Calendar |
| 15 | Y | If Yes, Enter location / organization administering the vaccine | (Narrative) |
| 16 | **Y** | **Have you been tested for the COVID-19 virus within the past 21 days** | Yes, No |
| 17 | N | If yes, list the results of the test, test type, and testing location. If no test, enter NONE. | (Narrative) |
| 18 | **Y** | **Have you been diagnosed as having the COVID-19 virus?** | Yes, No, Inconclusive |
| 19 | N | If yes, please select the date of your diagnosis. | Calendar |
| 20 | N | If yes, have you fully recovered from the COVID-19 virus? | Yes, No, Unknown |
| 21 | N | If Yes, Please provide details of your exposure, dates of testing, diagnosis, declaration of recovery by attending physician/org., and other details. | (Narrative) |
| 22 | **Y** | **Are you currently sick or feeling ill?** | Yes, No |
| 23 | N | If yes, describe your current symptoms | (Narrative) |
| 24 | **Y** | **Have you experienced a Fever within the last 14 days?** | Yes, No |
| 25 | N | If yes, detail your readings with approximate dates/times. | (Narrative) |
| 26 | **Y** | **Have you experienced any of the following within the last 14 days? (Check all that apply)** | OPTIONS: Shortness of Breath, Unusual Weakness, Unexplained Achiness, Loss of Taste, Loss of Smell, Occasional or Persistent Cough, None |
| 27 | N | Provide details for any items checked | (Narrative) |
| 28 | **Y** | **Are you recovering from any illness or injury within the past 14 days?** | Yes, No |
| 29 | N | If yes, list what type of verified illness / injury and provide details: | (Narrative) |
| 30 | **Y** | **Have you been to any foreign countries within in the past 21 days?** | Yes, No |
| 31 | N | If yes, list ALL foreign nations you have visited in the past 21 days | (Narrative) |
| 32 | **Y** | **Have you been: advised of possible exposure to COVID-19, approached about exposure via "contact tracing,” or exposed other known communicable diseases within the past 14 days?** | Yes, No, Maybe |
| 33 | N | If yes, please describe those circumstances and timeline | (Narrative) |
| 34 | **Y** | **Have you had any known, close personal contact with anyone having a confirmed diagnosis of COVID-19 in the past 21 days?** | Yes, No |
| 35 | N | If yes, Provide details of that contact / exposure. | (Narrative) |
| 36 | **Y** | **If required, are you willing, and physically able to continuously wear a personal face mask while participating on an embark?** | Yes, No |
|  |  |  |  |
|  |  | Signature | Calendar |
|  |  | Type name: | Date |
| **For Internal Use Only** |
|  |  | Signature | Calendar |
|  |  | Name: | Date |
|  |  | Title: |  |