UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN

TRAVELLERS' SURVEILLANCE FORM

We will appreciate if you respond to *ALL* questions.

A. TRAVELLER'S INFORMATION

1. Name: ……Age……Sex……
2. Nationality: ……Passport No……...Vessel/Flight/Vehicle Name/No……
3. Arrival: Date: ……Point of Entry: ……Seat No……
4. Purpose of Visit in Tanzania: Resident/Tourist/Transit/Business/Other (*Specify*)……...
5. Duration of stay in Tanzania (*days*): ……
6. Contact while in Tanzania;
   Physical/Home address……..……*Hotel name*……
   Street/Ward/District……..
   Mobile No: ……..*Email:* ……..
7. Country where the journey started: ……..
8. For the past 21 days (3 weeks) which countries have you visited?
   Country……Location visited/Province……Date……..No. of *days*……...
   Country……Location visited/Province……Date……..No. of *days*……
   Country……Location visited/Province……Date……..No. of *days*……
9. Do you have the following conditions or experienced them during the last 7 days (1 week)?
   Put Yes or No to each condition;

	Yes	No		Yes	No
Fever			*Joint/Muscle pain*		
Swollen glands			*Diarrhea*		
Vomiting			*Body weakness*		
Coughing/Shortness breathing			*Unusual bleeding*		
Skin rash			*Flu like symptoms*		
Jaundice			*Difficulty in swallowing*		
Headache			*Chills*		
Loss of appetite			*Paralysis*		
			Others (specify)		

10. In the last 21 days (3 weeks) have you: ***Put Yes or No to each question***
    i. Visited/resided in an area with ongoing disease outbreak i.e Ebola, Corona or Yellow fever? **Yes/No**
    ii. Participated in taking care of the sick person with symptoms above (Question 9)? **Yes/No**
    iii. Participated in the burial of the dead person? **Yes/No**

B. DECLARATION *(incorrect information is an offence)*

I hereby declare that the particulars and answers to the questions given in this Traveler Surveillance Form are true and correct.

Signature of the traveler……Date……

C. PUBLIC HEALTH MEASURES TAKEN *(for official use only)*

ACTION TAKEN: *1. Allowed to proceed* *2. Sent to secondary screening*

Name……..... Signature…… Date……

In case you feel **FEVER** and/or one of the following **SIGNS AND SYMPTOMS;**
persistent coughing, persistent vomiting, persistent diarrhea, headache, skin rash, bleeding without previous injury, confusion, flu like symptoms, Swollen glands, appearing obviously unwell
Please call Toll Free Number;
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