

FEDERAL MINISTRY OF HEALTH



PASSENGER SELF-REPORTING FORM

Every passenger and crew member on board this flight should complete this form in English

1. Family Name:		2. First Given Name:		3. Middle Name:	
4. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		5. Date of birth: ____/____/____	6. Passport Number:		7. Nationality
8. Country of residence and home address:		9. Tel. No. in country of residence:	10. Immediate destination in Nigeria: 11. Duration of stay at immediate destination:		
12. Address and Telephone No. while in Nigeria:					
13. Emergency contact in home country(next of kin) Name: Phone Number:			14. Emergency contact in Nigeria (next of kin) Name: Phone Number:		
15.a. Departure (and Transit) Airport	15.b. Date of Flight Departure ____/____/____	15.c. Destination Airport / Country	15.d. Name of Airline / Flight Number	15.e. Were you ill during this trip? <input type="checkbox"/> Yes <input type="checkbox"/> No	15.f. Did you see a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No
	____/____/____			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	____/____/____			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please check Yes or No to the following questions as appropriate:					
16. In the last 2 weeks did you have any of the following?					
a. Fever				<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Cough				<input type="checkbox"/> Yes <input type="checkbox"/> No	
c. Difficulty in Breathing				<input type="checkbox"/> Yes <input type="checkbox"/> No	
d. Generally feeling unwell				<input type="checkbox"/> Yes <input type="checkbox"/> No	
e. Symptoms of Flu or 'Common Cold'				<input type="checkbox"/> Yes <input type="checkbox"/> No	
17. In the last 2 weeks have you had contact with anyone who was ill/not feeling well?				<input type="checkbox"/> Yes <input type="checkbox"/> No (if 'Yes' go to 18, if 'No' go to 19)	
18. If yes to the above, what symptoms did they have					
a. Fever				<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Cough				<input type="checkbox"/> Yes <input type="checkbox"/> No	
c. Difficulty in Breathing				<input type="checkbox"/> Yes <input type="checkbox"/> No	
d. Generally feeling unwell				<input type="checkbox"/> Yes <input type="checkbox"/> No	
e. Symptoms of Flu or 'Common Cold'				<input type="checkbox"/> Yes <input type="checkbox"/> No	
19. Have you taken any of the following medications in the last 24hours?					
a. Paracetamol, Ibuprofen, or other pain relieving medications				<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Antibiotics				<input type="checkbox"/> Yes <input type="checkbox"/> No	
c. Antiviral drugs				<input type="checkbox"/> Yes <input type="checkbox"/> No	
d. Flu or 'common cold' medications				<input type="checkbox"/> Yes <input type="checkbox"/> No	

If you feel unwell, Call:

0909 299 6283, 0809 555 3232, 0800 970 000 - 10