

CREW COVID-19 STATUS CARD									
<p>Purpose of this card: Information to be recorded by crew prior to departure to confirm their COVID-19 health status and to facilitate processing by State's Public Health Authorities.</p> <p>Notwithstanding completion of this card, a crew member might still be subjected to additional screening by Public Health Authorities as part of a multilayer prevention approach e.g. when recorded temperature is 38 C° (100.4 F°) or greater.</p>									
<p>1. During the past 14 days, have you had close contact (face-to-face contact within 1 metre and for more than 15 minutes or direct physical contact) with someone who was suspected of having COVID-19 or had been diagnosed with COVID-19?"</p> <p style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></p>									
<p>2. Have you had any of the following symptoms during the past 14 days:</p> <table style="width: 100%; border: none;"> <tr> <td style="padding-right: 20px;">Fever</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> <tr> <td>Coughing</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> <tr> <td>Breathing difficulties</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> <tr> <td>Sudden loss of sense of taste or smell</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> </table>		Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>	Coughing	Yes <input type="checkbox"/> No <input type="checkbox"/>	Breathing difficulties	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sudden loss of sense of taste or smell	Yes <input type="checkbox"/> No <input type="checkbox"/>
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<p>3. Temperature at duty start:</p> <p>Temperature not recorded due to individual not feeling/ appearing feverish <input type="checkbox"/></p> <p>Temperature in degrees C° <input type="checkbox"/> / F° <input type="checkbox"/> : _____</p> <p>Date: _____ Time: _____</p> <p>Recording method : Forehead <input type="checkbox"/> Ear <input type="checkbox"/> Other <input type="checkbox"/> _____</p>									
<p>4. Have you had a positive COVID-19 test during the past 3 days?</p> <p style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Attach report if available</p>									
<p>5. Have you received a COVID-19 vaccine? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Date of most recent vaccination:</p> <p>Have you completed the full vaccination protocol? Yes <input type="checkbox"/> No <input type="checkbox"/></p>									
<p>Crew member Identification:</p> <p>Name:</p> <p>Airline/ aircraft operator:</p> <p>Nationality and Passport No:</p> <p>Signature:</p> <p>Date:</p>									
