MINISTRY OF HEALTH & POPULATION
Preventive Medicine Sector and public health
Central administration of public health
General Quarantine Administration

وزارة الصحة والسكان
قطـــاع الطب الوقائي والصحة العامة
الإدارة المركزية للصحة العامة
الادارة العامة للحجـــر الصحـــي

HEALTH DECLARATION FORM

To support public health surveillance and ensure the safety of all participants, please complete this form accurately before arriving in Egypt.

A. PERSONAL INFORMATION

Full Name: _____	**Date of birth:** ___/___/_____ **Age:** ____
Sex: ☐ **Male** ☐ **Female**	**Nationality:** _____
Passport Number: _____	**Occupation:** _____

B. TRAVEL INFORMATION

Date and time of arrival in Egypt: ___/___/_____ ___:___		**Airport of Arrival:** _____
Country of Departure: _____		**Airport of Departure:** _____
Airline Name: _____	**Flight Number:** _____	**Seat Number:** _____
Countries transited en route to Egypt: _____		

List every country, city, province/district/health zone and airport/border crossing visited or transited during the last 21 days. Attach an additional page if needed.

Date(s)	Country	City / province / district / health zone	Reason for stay / transit	Accommodation / contact there
___/___ to ___/___	_____	_____	_____	_____
___/___ to ___/___	_____	_____	_____	_____
___/___ to ___/___	_____	_____	_____	_____
___/___ to ___/___	_____	_____	_____	_____

C. ACCOMMODATION AND CONTACT DETAILS IN EGYPT

Hotel / Place of Stay in Egypt: _____	
Address in Egypt during your stay (up to the next 21 days): _____	
Mobile Phone: _____	**Alternative Number (WhatsApp):** _____
Email Address: _____	

D. OCCUPATIONAL INFORMATION

Do you work in any of the following fields?

☐ Healthcare Services ☐ Laboratory Services

☐ Mortuary, Funeral, or Corpse Preparation Services

☐ None of the Above

E. HEALTH STATUS DURING THE LAST 21 DAYS

Tick "Yes" for any symptom that occurred at any time during the last 21 days, even if it has resolved. Record the date of onset if known.

Symptom	No	Yes	Date of onset / comments
Fever or measured temperature ≥ 38°C	☐	☐	___/___/_____ _____
Severe weakness / unusual fatigue / intense malaise	☐	☐	___/___/_____ _____
Vomiting	☐	☐	___/___/_____ _____
Diarrhoea	☐	☐	___/___/_____ _____
Abdominal pain	☐	☐	___/___/_____ _____
Severe headache	☐	☐	___/___/_____ _____
Muscle or joint aches	☐	☐	___/___/_____ _____
Sore throat or difficulty swallowing	☐	☐	___/___/_____ _____
Skin rash	☐	☐	___/___/_____ _____
Unexplained bleeding, bruising, blood in vomit/stool/urine, or bleeding gums/nose	☐	☐	___/___/_____ _____
Red eyes / conjunctivitis	☐	☐	___/___/_____ _____
Difficulty breathing / chest pain	☐	☐	___/___/_____ _____
Have you taken fever-reducing medicine in the last 24 hours? ☐ No ☐ Yes: _____			
Have you sought medical care for any of the above symptoms? ☐ No ☐ Yes: where/when _____			
Were you admitted? ☐ No ☐ Yes			

F. EXPOSURE HISTORY

Answer all questions for the last 21 days. "Affected area" means any country, province, district or health zone listed by the competent public health authority based on current WHO / national updates.

Exposure question	Answer and details
Have you been in, lived in, worked in, or transited through an Ebola-affected area?	☐ No ☐ Yes ☐ Unknown Place/date: _____
Close contact with a person suspected/probable/ confirmed to have Ebola disease?	☐ No ☐ Yes ☐ Unknown Date/person/place: _____
Cared for, shared a room/household with, or transported a person with fever plus vomiting, diarrhoea or bleeding?	☐ No ☐ Yes ☐ Unknown Details: _____
Visited, worked in, or received care at a health facility where Ebola patients were treated or unexplained deaths occurred?	☐ No ☐ Yes ☐ Unknown Facility/date: _____
Attended or participated in a funeral/burial, body washing, or transport of remains in an affected area?	☐ No ☐ Yes ☐ Unknown Place/date: _____
Had contact with wild animals, carcasses, bats, primates, or bushmeat in an affected area?	☐ No ☐ Yes ☐ Unknown Details: _____

G. DECLARATION

I declare that the information provided is true and complete to the best of my knowledge. I understand that withholding or providing false information may endanger public health and may affect public health follow-up measures under applicable national regulations.

I agree to be contacted by authorized public health officials during the relevant monitoring period if risk assessment indicates follow-up is needed. I will immediately call the public health hotline / event medical team and avoid public transport or crowded places if I develop fever or symptoms during the 21 days after my last possible exposure.

The information in this form will be used only for public health surveillance, risk assessment, referral, contact tracing and related measures. It should be stored securely, accessed only by authorized personnel, and retained only for the period required by national public health regulations.

Signature: _____ **Date:** ___/___/___

Thank you for helping us to protect your health and that of others.