REPUBLIC OF BOTSWANA
Ministry of Health

TEL: (+267) 363 2899

EBOLA SCREENING TOOL FOR POINTS OF ENTRY

THIS FORM IS INTENDED TO SUPPORT PUBLIC HEALTH AUTHORITIES BY ALLOWING ARRIVING TRAVELERS TO EASILY PROVIDE RELEVANT INFORMATION PERTAINING TO THEIR HEALTH STATUS. NOTWITHSTANDING COMPLETION OF THIS FORM, TRAVELERS MIGHT BE SUBJECTED TO ADDITIONAL HEALTH SCREENING BY THE PUBLIC HEALTH AUTHORITY. THE INFORMATION IS INTENDED TO BE HELD IN ACCORDANCE WITH APPLICABLE NATIONAL LAWS AND USED ONLY FOR PUBLIC HEALTH PURPOSES.

NAME _____

AGE _____ SEX _____

OCCUPATION _____

RESIDENCY/PLACE OF STAYING IN BOTSWANA _____ VILLAGE/TOWN _____

PLOT NO _____

TELEPHONE (HOME/CELL) _____ EMAIL _____

COUNTRY OF DEPARTURE _____ DATE ___/___/_____

FLIGHT NO/CAR REG NO _____ PURPOSE OF VISIT _____

EMERGENCY CONTACT PERSON _____ CONTACT _____

HAVE YOU BEEN TO OR PASSED THROUGH EBOLA AFFECTED COUNTRIES IN THE LAST 21 DAYS? ☐ YES ☐ NO

IF YES, PLEASE LIST THE COUNTRIES VISITED OR TRANSITED _____

DO YOU HAVE THE FOLLOWING SIGN AND SYMPTOMS?

FEVER	☐ YES	☐ NO
HEADACHE	☐ YES	☐ NO
MUSCLE ACHES/ JOINTS	☐ YES	☐ NO
LOSS OF APPETITE	☐ YES	☐ NO
ABDOMINAL PAIN	☐ YES	☐ NO
LETHARGY/WEAKNESS	☐ YES	☐ NO
DIARRHOEA	☐ YES	☐ NO
VOMITING	☐ YES	☐ NO
DIFFICULTY IN BREATHING	☐ YES	☐ NO
HICCUPS	☐ YES	☐ NO

SIGNS

BLEEDING FROM ANY BODY ORIFICES (MOUTH, SKIN, NOSE, EYES) _____

DATE OF ONSET OF SYMPTOMS ___/___/_____

SIGNATURE _____ **DATE** ___/___/_____

FOR OFFICIAL USE ONLY

TEMPERATURE ☐ ^{O}C

RECEIVED BY _____ DATE ___/___/_____