## MEDICAL DECLARATION FORM

## This is important document, your information is vital to allow health authorities contact you to prevent communicable diseases

E II DI OOK I ETTE	DC).				
• Full name (BLOCK LETTE	(KS):				• • • • • • • • • • • • • • • • • • • •
• Date of Birth:	Gend	ler:	Nationality:		
Passport number or other le	gal documen	ıt:			
Travel information: Plane	Ship □ Aut	omobile	☐ Other (clarify):		
Transportation No.:		Seat	: No.:		
Departure date: //	Im	migatior	n date: //		
Place of departure (province/	country):				
Place of destination (province	e/country):				
In the past 14 days, have you	been to any	province	e/city/territory/country? If y	es, where?	?:
Contact information in Viet	t Nam				
Staying address:					
• Tel./Mob.:		Е	mail:		
If you have any of the follow					
If you have any of the follow					
If you have any of the follow entry/exit/transit)?	vings at pre	sent or	during the past 14 days (u	ntil the da	te of
If you have any of the follow entry/exit/transit)?  Symptoms	Yes	No	during the past 14 days (u Symptoms	ntil the da	te of No
If you have any of the followentry/exit/transit)?  Symptoms Fever	Yes	No [ ]	Symptoms  Vomiting	ntil the da	No [ ]
If you have any of the followentry/exit/transit)?  Symptoms Fever Cough	Yes [ ] [ ]	No []	Symptoms  Vomiting Diarrhea	Yes	No []
If you have any of the followentry/exit/transit)?  Symptoms Fever Cough Difficulty of breathing Sore throat	Yes  [ ]  [ ]  [ ]	No [ ] [ ] [ ] [ ]	Symptoms  Vomiting Diarrhea Rash Skin haemorrhage	Yes [ ] [ ] [ ]	No [ ] [ ] [ ] [ ]
If you have any of the followentry/exit/transit)?  Symptoms Fever Cough Difficulty of breathing Sore throat List of vaccines or biological	Yes  [ ]  [ ]  [ ]  [ ]  als used:	No [ ] [ ] [ ] [ ]	Symptoms  Vomiting Diarrhea Rash Skin haemorrhage	Yes [ ] [ ] [ ]	No [ ] [ ] [ ] [ ]
If you have any of the followentry/exit/transit)?  Symptoms Fever Cough Difficulty of breathing Sore throat List of vaccines or biological History of exposure: During	Yes  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [	No [ ] [ ] [ ] days, d	Symptoms  Vomiting Diarrhea Rash Skin haemorrhage	Yes [] [] []	No [ ] [ ] [ ] [ ]
If you have any of the followentry/exit/transit)?  Symptoms Fever Cough Difficulty of breathing Sore throat List of vaccines or biological	Yes  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [	No [ ] [ ] [ ] days, diet/slaug	Symptoms  Vomiting Diarrhea Rash Skin haemorrhage	Yes [] [] []	No [ ] [ ] [ ] [ ]

The information I have given is true, correct and complete. I understand failure to answer any question may have serious consequences.

Day: Month: Year: 202
-----------------------

Signature	of Passenger	/ Crew
-----------	--------------	--------

$\bigcirc$	任夕	DUIVBLE	$T\Lambda R\Omega$	(大文字)
\ <b>T</b> /	$\Gamma$	LOLANIO	IANO	$(\mathcal{N} \times \mathcal{T})$

- ② 生年月日 27FEB85 / 性別 男 male 女 female / 国籍 JAPAN
- ③ パスポートナンバー又は法的本人確認番号
- ④ 旅行情報: 飛行機 船 車 その他:(記入)
- ⑤ 交通手段 番号:(飛行機フライトナンバー等) / 座席番号
- ⑥ 出発日 / 到着日
- ⑦ 出発場所(州/国)
- ⑧ 目的地 (州/国)
- ⑨ 過去14日間にどこかの 州/市/地域/国 に行きましたか? YES の場合どちらに行きましたか?
- ⑩ ベトナム滞在中の連絡先ベトナムの滞在先住所(ホテル等)電話番号 Eメール
- ⑪ 現在又は過去14日間に以下の症状がありましたか?

A熱 B咳 C呼吸困難 D喉の痛み

E嘔吐 F下痢 G発疹 H皮膚出血

- ② 使用したワクチン又は生物学的製剤を記載下さい。
- ③ 過去14日間に養鶏場、動物市場、食肉処理場等を訪れたり 動物との接触がありましたか?
- ⑭ 過去14日間に伝染病患者の世話をしましたか?
- ⑤ 質問結果に正確に答えないと重大な結果をもたらす可能性があることを理解しております。

記載の情報は真実であり間違いはありません。

記入日 直筆のサイン