

UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN



TRAVELLERS' SURVEILLANCE FORM

This is a form with questions that will assist to prevent highly communicable diseases such as Ebola.
We will appreciate if you respond to ALL questions.

A. TRAVELLER'S INFORMATION

1. Name:Age.....Sex.....
2. Nationality:Passport No.....Vessel/Flight/Vehicle Name/No.....
3. Arrival: Date:Point of Entry:Seat No.....
4. Purpose of Visit in Tanzania: Resident/Tourist/Transit/Business/Other (*Specify*).....
5. Duration of stay in Tanzania (*days*):
6. Contact while in Tanzania;
Physical/Home address.....*Hotel name*.....
Street/Ward/District.....
Mobile No:*Email:*
7. Country where the journey started:
8. For the past 21 days (3 weeks) which countries have you visited?

Country.....	Location visited/Province.....	Date.....	No. of days.....
Country.....	Location visited/Province.....	Date.....	No. of days.....
Country.....	Location visited/Province.....	Date.....	No. of days.....

9. Do you have the following conditions or experienced them during the last 7 days (1 weeks)?

Put Yes or No to each condition;

	Yes	No		Yes	No
<i>Fever</i>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Joint/Muscle pain</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Swollen glands</i>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Diarrhea</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Vomiting</i>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Body weakness</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Coughing/Shortness breathing</i>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Unusual bleeding</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Skin rash</i>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Flu like symptoms</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Jaundice</i>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Difficulty in swallowing</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Headache</i>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Chills</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Loss of appetite</i>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Paralysis</i>	<input type="checkbox"/>	<input type="checkbox"/>
			<i>Others (specify)</i>		

10. In the last 21 days (3 weeks) have you: **Put Yes or No to each question**

- i. Visited/resided in an area with ongoing disease outbreak i.e Ebola, Corona or Yellow fever? **Yes/No**
- ii. Participated in taking care of the sick person with symptoms above (Question 9)? **Yes/No**
- iii. Participated in the burial of the dead person? **Yes/No**

Signature of the traveler.....**Date**.....

B. PUBLIC HEALTH MEASURES TAKEN (for official use only)

ACTION TAKEN: 1. Allowed to proceed 2. Sent to secondary screening

Name..... **Signature**..... **Date**.....



In case you feel **FEVER** and/or one of the following **SIGNS AND SYMPTOMS**;
persistent coughing, persistent vomiting, persistent diarrhea, headache, skin rash, bleeding without previous injury,
confusion, flu like symptoms, Swollen glands, appearing obviously unwell

Please call Toll Free Number;
0800110124 or 0800110125