Republic of Zambia
MINISTRY OF HEALTH
MEDICAL DECLARATION FORM M0109 CB

Date			
			Tick
Full Names/Nom et post-nom:			
Sex/Sexe:		Male	
		Female	
Nationality/Nationalité		Passport No.	
Arrived from/En provenance de:			
Proceeding to/Partance pour:			
Residential Address in Zambia/Adresse residentielle en Zambie:			
Phone No.:			

Did you visit or pass through any4 of the following countries in the past two weeks ?(a) Guinea (b) liberia (c) Congo (d) Uganda (e) Gabon (f) South Sudan (h) Ivory Coast (i) Nigeria
Other West African countries? Please specify .....

HAVE YOU EXPERIENCED THE FOLLOWING IN THE LAST 7 DAYS?			
	YES	NO	DR's Remarks/Commentaires Du Médecin
FEVER/FIEVRE			
COUGH/TOUX			
RUNNY NOSE/RHINORHEE			
SORE THROAT/DOULEUR DE GORE			
HEADACHE/CEPHALE/MAUX DE TETE			
JOINT/BODY PAINS/ MUSCLE ACHES			
CHILLS/RISSONS			
VOMITING/VOMISSEMENT			
DIARRHOEA/DIARRHEE			
WEAKNESS			
STOMACH PAIN			
LACK OF APPETITE			
A RASH			
RED EYES			
HICCUPS			
CHEST PAIN			
DIFFICULTY BREATHING			
DIFFICULTY SWALLOWING			
BLEEDING			
Signature:			