

Pre-boarding health declaration questionnaire

		DATE OF TRIP	TIME OF TRIP	PORT OF EMBARKATION


Surname in Passport:	First Name	SEX	DATE OF BIRTH	NATIONALITY	Father's Name
Surname of all children under 18 years old	First Name of all children	SEX	DATE OF BIRTH	NATIONALITY	Father's Name

Within the past 14 days	YES	NO
1. Have you or has any person listed above, presented sudden onset of symptoms of fever or cough or difficulty in breathing or sudden onset of anosmia, ageusia or dysgeusia?		
2. Have you, or has any person listed above, had close contact with anyone diagnosed as having coronavirus COVID-19?		
3. Have you, or has any person listed above, provided care for someone with COVID-19 or worked with a health care worker infected with COVID-19?		
4. Have you, or has any person listed above, visited or stayed in close proximity to anyone with COVID-19?		
5. Have you, or has any person listed above, worked in close proximity to or shared the same classroom environment with someone with COVID-19?		
6. Have you, or has any person listed above, travelled with a patient with COVID-19 in any kind of conveyance?		
7. Have you, or has any person listed above, lived in the same household as a patient with COVID-19?		

Test results and vaccination	
8. Have you been tested for COVID-19 with a molecular method (PCR) within the past 72 hours?	<input type="checkbox"/> No
	<input type="checkbox"/> Pending results
	<input type="checkbox"/> Positive 1
	<input type="checkbox"/> Negative
9. Have you performed, this day or the day before, a rapid test for COVID-19?	<input type="checkbox"/> No
	<input type="checkbox"/> Positive 2
	<input type="checkbox"/> Negative
10. Have you been vaccinated with all the necessary doses for COVID-19?	<input type="checkbox"/> No
	<input type="checkbox"/> Yes

1 or 2 Embarkation onboard the ship is prohibited only if there is an affirmative answer

Our Ship fulfills all the imposed health protocols. Each passenger travels at his own responsibility.

Contact telephone number for the next 14 days 	
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