MANDATORY STATE OF HAWAI'I TRAVEL AND HEALTH FORM
FOR ALL PASSENGERS AND CREW MEMBERS
The State of Hawai'i actively screens and monitors travelers for public health and safety.
It is required that all travelers provide the information below.
Hawaii Revised Statutes Section 127A-12 and 127A-13

(For children under the age of 18 years traveling with a parent/guardian please fill out first name, last name, birthdate, and Health History, and sign on behalf of the child.)

TRAVELER INFORMATION:

First Name

Middle Initial(s)

Last Name

Home Address Number and Street

City/Town

State

Zip Code

Government ID Type:

ID No.

Gender (optional)

Race (optional):

What industry do you work in? (e.g., Health, Construction, Retail)

What is your occupation?

Have you signed a 14-day quarantine order that is currently in effect?  

Yes  No

CONTACT TELEPHONE IN HAWAII:

Primary ( ) - Secondary ( )

FLIGHT INFORMATION:

Arriving Airline

Flight No.

Travel Date (MM/DD/YY)

Departing Airline

Departing Flight No.

Travel Date (MM/DD/YY)

DESTINATION LOCATION:

Purpose of Visit:

Vacation  Returning Resident  Visiting Family/Friends  Business  Relocate to HI

Hotel Lodging/Name

Destination Address or Hotel Name

City/Town

State

Zip Code
## TRAVEL INFORMATION:

Have you traveled outside the State of Hawai‘i in the last 14 days?  ○ Yes  ○ No

If Yes, Where?

<table>
<thead>
<tr>
<th>Country or State:</th>
<th>From? (MM/DD/YY)</th>
<th>To? (MM/DD/YY)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## HEALTH HISTORY:

Do you feel ill now?  ○ Yes  ○ No

Are you feeling any of these symptoms now?

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New cough</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headache</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Runny or stuffy nose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shortness of breath</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vomiting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin rash</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of taste or smell</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tiredness/fatigue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muscle ache</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest pain or pressure</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Have you taken medicine to bring down fever? (e.g., Tylenol or ibuprofen)  ○ Yes  ○ No

Have you had a flu vaccine in the last year?  ○ Yes  ○ No

Date of vaccination? (MM / YY)  ____________________

In what country?  ____________________

## ATTESTATION:

I declare under penalty of law that all the information provided herein is true and correct to the best of my knowledge and belief.

____________________________  ____________________
(Signature)                  (Date)

____________________________
(Print Name)

☐ On behalf of a minor, under the age of 18 years

The information on this form will be used for Department of Health purposes and will be treated as confidential information. The information will be used, to the extent deemed necessary by the department, for the detection of a communicable or dangerous disease and for related prevention, investigation, monitoring, quarantine, or isolation.

## OFFICIAL SCREENER USE ONLY:

Exemption Status

☐ Military  ☐ CISA  ☐ Covidexemption Letter

☐ Negative State Approved Test