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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.
Hawai'i 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:

Passport Driver's License/ID Card Visa Other

ID No.

Email Address: _____

Gender (optional) Male Female Non-Binary

Birthdate (MM/DD/YYYY) / /

Race (optional):

American Indian/Alaska Native Other Pacific Islander
 Asian White
 Black/African-American Other
 Native Hawaiian

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



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TRAVEL INFORMATION:

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

If Yes, Where?

From? (MM/DD/YY)

To? (MM/DD/YY)

Country or State: _____

/ /

to

/ /

Country or State: _____

/ /

to

/ /

HEALTH HISTORY:

Do you feel ill now? Yes No

Are you feeling any of these symptoms now?

	Yes	No		Yes	No
Fever	<input type="radio"/>	<input type="radio"/>	Vomiting	<input type="radio"/>	<input type="radio"/>
Chills	<input type="radio"/>	<input type="radio"/>	Diarrhea	<input type="radio"/>	<input type="radio"/>
New cough	<input type="radio"/>	<input type="radio"/>	Skin rash	<input type="radio"/>	<input type="radio"/>
Sore throat	<input type="radio"/>	<input type="radio"/>	Loss of taste or smell	<input type="radio"/>	<input type="radio"/>
Headache	<input type="radio"/>	<input type="radio"/>	Tiredness/fatigue	<input type="radio"/>	<input type="radio"/>
Runny or stuffy nose	<input type="radio"/>	<input type="radio"/>	Muscle ache	<input type="radio"/>	<input type="radio"/>
Shortness of breath	<input type="radio"/>	<input type="radio"/>	Chest pain or pressure	<input type="radio"/>	<input type="radio"/>

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