MANDATORY STATE OF HAWAIʻI 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 17 years and younger traveling with a parent/guardian please fill out first name, last name, birthdate, and Health History Parts 1 and 2 only, and sign on behalf of the child.)

TRAVELER INFORMATION:

First Name

Middle Initial(s)

Last Name

Home Address Number and Street

City

State

Zip Code

OR Country:

Contact Telephone in Hawai'i - Primary ( ) -

Contact Telephone in Hawai'i - Secondary ( ) -

Country of Citizenship:

Email Address: _____

Gender (optional) ○ Male ○ Female ○ Non-Binary

Birthdate (MM/DD/YYYY) / /

Race (optional):
○ American Indian/Alaska Native
○ Asian
○ Black/African-American
○ Native Hawaiian
○ Other Pacific Islander
○ White
○ Other

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

FLIGHT INFORMATION: This information, along with your name and contact information, may be used for contact tracing, as well as quarantine enforcement.

Departure: Airline | Flight No. | Travel Date (MM/DD/YY) / /

Return: Airline | Flight No. | Travel Date (MM/DD/YY) / /

Destination Address or Hotel Name

City

State HI

Zip Code -

TRAVEL INFORMATION:

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

Where?	When?	
Country or State: _____	From (MM/DD/YY) / /	To (MM/DD/YY) / /
Country or State: _____	From (MM/DD/YY) / /	To (MM/DD/YY) / /
Country or State: _____	From (MM/DD/YY) / /	To (MM/DD/YY) / /

HEALTH HISTORY (PART 1)

Do you feel ill now? ○ Yes ○ No (Skip to Health History Part 2)

Are you feeling any of these symptoms now?

	Yes	No		Yes	No
Fever	○	○	Vomiting	○	○
Chills	○	○	Diarrhea	○	○
New cough	○	○	Skin rash	○	○
Sore throat	○	○	Loss of taste or smell	○	○
Headache	○	○	Tiredness/fatigue	○	○
Runny or stuffy nose	○	○	Muscle ache	○	○
Shortness of breath	○	○	Chest pain or pressure	○	○

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

HEALTH HISTORY (PART 2)

Were you ever in contact with a person confirmed to have COVID-19?
○ Yes ○ No

When? (MM / YY)
☐☐ / ☐☐

Have you ever been tested for COVID-19?
○ Yes ○ No

When? (MM / YY)
☐☐ / ☐☐

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, 17 years or younger.**

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.