Symptom form

Helsedirektoratet
Norwegian Directorate of Health

Name: _____

Date of birth: DD MM YYYY

Nationality: _____

Name of ship: _____

Shipping agent: _____

Date: DD MM YYYY

Do you have any symptoms which could be caused by COVID-19?

☐ YES ☐ NO

If yes, what symptoms do you have?

☐ Fever
☐ Cough
☐ Sore throat
☐ Breathlessness
☐ General malaise
☐ Loss of sense of taste or smell

If so, on what day did the symptoms start?

_____

Signature: _____