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Infectious Disease Screening Tool

Lying on this form could subject you to criminal and civil legal action.

Patient Name:_____ **Date:**_____

Please answer all questions below:

1) Have you had known exposure or tested positive to COVID-19 ? □ **Yes** □ **No**
   If yes, when _____
   If treated explain:_____

2) Have you had contact with a person with Ebola/Lassa/Marburg, Middle Eastern Respiratory Virus (MERS), Measles, Mumps, Chickenpox, or any other known infectious disease? □ **Yes** □ **No**

3) Do you have a fever (Temp more than 100.4°F (38°C)) or feel hot? □ **Yes** □ **No**

4) Do you have a cough, shortness of breath, or a sore throat □ **Yes** □ **No**
   If yes, how long have you had these symptoms:_____

5) Are you vomiting or have diarrhea? □ **Yes** □ **No**

If you answered "yes" to any question, please notify staff IMMEDIATELY for further instructions.