GCRU COMMUNICABLE DISEASE SCREENING FORM

Protocol:__________________  Date:_____/_____/________

Participant Initials:  First _____  Last _____                  Participant family/friend initials:First_____Last____

Participant ID_______________Oral Temperature___________F/C       Time:__________AM/PM

1. Have you been in contact with someone who is/was sick?
   □ Yes How many days ago?_______
   □ No

2. Do you have or had any of the following symptoms in the past 14 days (1-2 weeks)?
   □ None of these    □ Unable to assess    □ Abdominal pain    □ Bruising or bleeding
   □ Cough          □ Diarrhea            □ Fever              □ Joint pain
   □ Muscle pain    □ Rash               □ Red eye            □ Severe headache
   □ Shortness of breath □ Vomiting        □ Weakness

3. Have you traveled internationally in the past month?
4. If Yes
   Where?__________________
   Was it a direct flight: ___Yes       ___No
   If yes where was the layover:_________________   for how long?______mins/hours
   Travel dates: from_____/_____/________ to _____/_____/________

   □ No

5. Have you attended any large gathering(s)/event(s) (Concert, movies, theater, games, church etc.) or gathering(s) of more than 10 people:
   □ Yes Where:_______________

   Date:_____/_____/_______ or How long ago ___________Day(s)/Week(s)/Months(s)
   For how long?______mins/hours
   □ No

GCRU staff completing screening:__________________________________

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