Rush-Copley Medical Center

HEALTH SCREENING FORM

Visitor Name: _____

School: _____

In an effort to ensure the safety of all patients in our unit, visitors will be screened for the following communicable illnesses. We ask you to provide the information to the best of your knowledge.

Have you had any of these symptoms in the last three days?

Fever	☐Yes	☐ No	Runny Nose	☐Yes	☐ No
Cough	☐Yes	☐ No	Diarrhea	☐Yes	☐ No
Sore throat	☐Yes	☐ No	Vomiting	☐Yes	☐ No
Sore ears	☐Yes	☐ No	Rash/skin sores	☐Yes	☐ No
Watery/sore eyes	☐Yes	☐ No	Lice	☐Yes	☐ No

*** If you answer yes, please discuss with Employee Health Services***

Have you been around anyone ill or exposed to the following diseases in the last six weeks?

Chicken Pox	☐Yes	☐ No	Scarlet fever	☐Yes	☐ No
Measles	☐Yes	☐ No	German measles	☐Yes	☐ No
Hepatitis	☐Yes	☐ No	Whooping cough	☐Yes	☐ No
Other: _____	☐Yes	☐ No			

*** If you answer yes, please discuss with Employee Health Services***

Must attach proof of vaccination history. Please list dates of vaccinations below.

Drug Screen date: _____ positive/negative

TB Skin Test date: #1 _____ #2 _____ or previous positive date: _____ Chest x-ray: _____

Measles vaccine: #1 _____ #2 _____ or Titer Positive: _____

Mumps vaccine: #1 _____ #2 _____ or Titer Positive: _____

Rubella vaccine: #1 _____ or Titer Positive: _____

Varicella vaccine: #1 _____ #2 _____ or Titer Positive: _____ or history of doctor verified disease statement: _____

Tdap: _____

Influenza: _____ (Required October 1 – March 31)

For Clinical Students only:

Hepatitis B vaccine: #1 _____ #2 _____ #3 _____ or Titer Positive: _____

I verify that the above information is correct to the best of my knowledge.

_____ _____

Signature Date

Revised 11.01.2023