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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