

Community Medical Center

HEALTH CARE WORKER INFLUENZA MONITORING FORM

Name: _____ Department: _____

Job Title: _____

Date/s of exposure to known Influenza patient: _____

Type of contact with patient, patient environment, or virus: _____

Was personal protective equipment (PPE) used? No Yes

If yes, list PPE used: Gown Gloves Face Shield Shoe Covers
 Particulate Respirator Surgical Mask Eye Protection

Please check your temperature daily before reporting for work and monitor yourself for any of the following influenza-like symptoms (SX):

- | | |
|--|----------------------|
| Fever 100.0 or > | Cough |
| Acute onset of respiratory illness | Sore throat |
| GI symptoms (diarrhea, vomiting, abdominal pain) | Muscle or joint pain |
| (If activity in community, or have been in contact with confirmed patient) | |

Day 1	Day 2	Day 3	Day 4	Day 5
Date: _____	Date: _____	Date: _____	Date: _____	Date: _____
AM Temp: _____	AM Temp: _____	AM Temp: _____	AM Temp: _____	AM Temp: _____
PM Temp: _____	PM Temp: _____	PM Temp: _____	PM Temp: _____	PM Temp: _____
SX: No <input type="checkbox"/> Yes <input type="checkbox"/>	SX: No <input type="checkbox"/> Yes <input type="checkbox"/>	SX: No <input type="checkbox"/> Yes <input type="checkbox"/>	SX: No <input type="checkbox"/> Yes <input type="checkbox"/>	SX: No <input type="checkbox"/> Yes <input type="checkbox"/>

Day 6	Day 7	Day 8	Day 9	Day 10
Date: _____	Date: _____	Date: _____	Date: _____	Date: _____
AM Temp: _____	AM Temp: _____	AM Temp: _____	AM Temp: _____	AM Temp: _____
PM Temp: _____	PM Temp: _____	PM Temp: _____	PM Temp: _____	PM Temp: _____
SX: No <input type="checkbox"/> Yes <input type="checkbox"/>	SX: No <input type="checkbox"/> Yes <input type="checkbox"/>	SX: No <input type="checkbox"/> Yes <input type="checkbox"/>	SX: No <input type="checkbox"/> Yes <input type="checkbox"/>	SX: No <input type="checkbox"/> Yes <input type="checkbox"/>

Day 11	Day 12	Day 13	Day 14	Day 15
Date: _____	Date: _____	Date: _____	Date: _____	Date: _____
AM Temp: _____	AM Temp: _____	AM Temp: _____	AM Temp: _____	AM Temp: _____
PM Temp: _____	PM Temp: _____	PM Temp: _____	PM Temp: _____	PM Temp: _____
SX: No <input type="checkbox"/> Yes <input type="checkbox"/>	SX: No <input type="checkbox"/> Yes <input type="checkbox"/>	SX: No <input type="checkbox"/> Yes <input type="checkbox"/>	SX: No <input type="checkbox"/> Yes <input type="checkbox"/>	SX: No <input type="checkbox"/> Yes <input type="checkbox"/>

Day 16	Day 17	Day 18	Day 19	Day 20
Date: _____	Date: _____	Date: _____	Date: _____	Date: _____
AM Temp: _____	AM Temp: _____	AM Temp: _____	AM Temp: _____	AM Temp: _____
PM Temp: _____	PM Temp: _____	PM Temp: _____	PM Temp: _____	PM Temp: _____
SX: No <input type="checkbox"/> Yes <input type="checkbox"/>	SX: No <input type="checkbox"/> Yes <input type="checkbox"/>	SX: No <input type="checkbox"/> Yes <input type="checkbox"/>	SX: No <input type="checkbox"/> Yes <input type="checkbox"/>	SX: No <input type="checkbox"/> Yes <input type="checkbox"/>

If any symptoms of influenza-like illness occur, immediately limit your interactions with others, including patients. Notify your supervisor immediately.

Return form to Infection Prevention Office