Communicable Disease Screening Questionnaire

To ensure participant safety VOANS Senior CommUnity Care requires all staff to be medically cleared for communicable diseases before engaging in direct participant contact. This tool is intended to screen for symptoms and exposure to communicable diseases.

Employee Name:	**Location:**

Communicable Disease Screening

Based on the responses to the below questions, the registered nurse (RN) reviewing this document may refer you for a follow-up appointment with your physician, nurse practitioner, or physician's assistant.

Are you currently experiencing any of the following symptoms?

□ Headache	□ Testicle pain / tenderness □	□ Stiff neck
□ Loss of smell / taste	Increased light sensitivity □	□ Trouble chewing
□ Swollen glands to neck.	Mild conjunctivitis	□ Apnea (breathing repeatedly starts and stops)
□ Muscle / body aches	□ Vomiting / nausea	□ Blister-like rash on face, torso, arms or legs
□ Dislike of bright lights	□ Loss of appetite	□ Swollen lymph nodes
□ Seizures	□ Cold – like symptoms	□ Pain on swallowing
□ Mild pain in front of neck.	□Difficulty breathing	□ Pain in the chest
□ Sore Throat	□ Drowsiness	□ Weakness
□ Runny Nose	□ Pus on tonsils	□ Night sweats
□ Nasal Discharge	□ Bloody sputum	□ Fatigue
□ Inflamed Eyes	□ Chills	□ Rash
□ Itching	□ Fever	□ Other:

In the past week, have you been exposed to any of the following diseases:

□ Yes □ No □	1. COVID-19
Yes □ No □	2. Diphtheria
Yes □ No □	3. Influenza
Yes □ No □	4. Measles
Yes □ No □	5. Meningitis / Meningococcal Disease
Yes □ No □	6. Mumps
Yes □ No □	7. Pertussis
Yes □ No □	8. Pneumococcal Disease
Yes □ No □	9. Rubella
Yes □ No □	10. Streptococcal Infection
Yes □ No □	11. Varicella Zoster Virus
Yes □ No	12. Tuberculosis - TB

I acknowledge that the above information is true and correct to the best of my knowledge.

Signature:	**Date:**

Office Use Only	□ Yes □ No	I have conducted a screening and have reviewed the information on this form. The employees has not screened positive for communicable diseases.	
	□ Yes □ No	The employee has been referred to a physician, NP, or PA for physical examination.	
	Signature – RN Screener:	**Printed Name:**	**Date:**

Please email the completed form to: ProviderRelationsCentral@voa.org