Fermilab

Influenza Screening

Medical Office/ESH
Mail Stop 204
Phone: 630-840-3232
Fax: 630-840-3053

Date _____ Time Called _____ ☐ AM ☐ PM

Primary work location in last 7 days _____

Living on site? ☐ Yes ☐ No Location _____

Name: _____ ID# _____ Div/Sec _____

Phone # can be reached _____ Supervisor notified? ☐ Yes ☐ No

EMPLOYEE MUST STILL INFORM THEIR SUPERVISOR

Date of onset of symptoms _____

Date of first presentation to health care system _____

Confirmed or diagnosed by personal physician ☐ Yes ☐ No ☐ Unk

				Comment
Fever > 100 degrees F (38 degrees C)	☐ Yes	☐ No	☐ Unk	_____
Sore throat	☐ Yes	☐ No	☐ Unk	_____
Dry cough	☐ Yes	☐ No	☐ Unk	_____
Diarrhea	☐ Yes	☐ No	☐ Unk	_____
Did you return from travel outside of the US within the last 7 days?	☐ Yes	☐ No	If so, where:	_____

NOTE: FOR VISITORS ONLY Please complete what information you can:

Fermilab Supervisor: _____ Experiment # _____ Div/Sec _____

*** MEDICAL NEEDS TO CALL THE SUPERVISOR WHEN A VISITOR REPORTS FLU-LIKE SYMPTOMS TO THE MEDICAL OFFICE.

Advice _____

Medical person's signature _____ Date _____

ESH/Medical

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Print Form