TRAVEL SCREENING INFORMATION

Optim Health System is following the Centers for Disease Control and Prevention travel screening guidelines. Please complete the following questions:

HAVE <u>YOU OR ANYONE</u> YOU ARE IN CLOSE CONTACT WITH…

Been in contact with anyone that has been diagnosed or is being monitored by the CDC for COVID-19 in the last 30 days?	☐ **Yes**	☐ **No**
Traveled via any method (i.e. plane, bus, train, ship, car) **<u>in or out</u>** of the US where positive COVID-19 cases have been identified in the last 30 days?	☐ **Yes**	☐ **No**
If yes, what City / State / Country did you / they visit? _____		

Are you / they currently experiencing any of the following symptoms?

Fever (greater than 100.4°F / 38.0°C)	☐ **Yes**	☐ **No**
Severe Headache	☐ **Yes**	☐ **No**
Muscle Pain / Weakness	☐ **Yes**	☐ **No**
Diarrhea / Vomiting / Abdominal Pain	☐ **Yes**	☐ **No**
Respiratory Symptoms / Shortness of Breath	☐ **Yes**	☐ **No**
Rash / Skin Irritation	☐ **Yes**	☐ **No**
Unexplained Bleeding or Bruising	☐ **Yes**	☐ **No**

Printed Name **Signature** **Date** **Time**

Clinical Staff Notification Required? _____Yes _____No

☐ Language/Translation Line Utilized

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