University of Iowa Stead Family Children's Hospital
Visitor Health Screening Form

Thank you for protecting the health of all patients at University of Iowa Stead Family Children's Hospital by truthfully filling out this form. Any visitor who has symptoms of an illness MAY NOT VISIT until they are healthy. This form will be kept on file by the hospital and your group leader in case follow-up is needed.

Group leader name and phone number (please print): ________________________________

Visitor name: ____ **Date of Visit:** ____________

Have you had any of these symptoms this past week (7 days)?

___Yes ___No Fever
___Yes ___No Runny nose
___Yes ___No Sore throat
___Yes ___No Cough
___Yes ___No Diarrhea, Nausea, or Vomiting
___Yes ___No Skin infection, sores, or rash of any kind
___Yes ___No Eye infection or drainage (pink eye or conjunctivitis)
___Yes ___No Cold sore or fever blister
___Yes ___No Lice

Have you been exposed to any of these symptoms this past week (7 days)?

___Yes ___No Fever
___Yes ___No Diarrhea, Nausea, or Vomiting

Do you have or have you been exposed to any of these in the past three weeks (21 days)?

___Yes ___No "Whooping Cough" (Pertussis)
___Yes ___No Chicken Pox or Shingles
___Yes ___No German Measles (Rubella)
___Yes ___No Red Measles (Rubeola)
___Yes ___No Mumps

___Yes ___No Have you received FluMist Influenza Vaccine within the past 14 days?
*If "Yes", visitor MAY NOT VISIT until 2 weeks after vaccine administration.

UICH Staff: If "yes" to any items, restrict visit. Questions? Call Hosp. Epidemiology 8a-5p M-F at 6-1606. After hours, pager #3158

___________ ____
Date **Signature of group leader conducting visitor health screening**

Or

___________ ____
Date **Signature of hospital staff member reviewing visitor health screening**