Communicable Diseases Screening
Initial and Annual

The Wisconsin Department of Health and Human Services requires that personal care agencies or providers periodically screen all health care staff to ensure that he/she is free of any communicable diseases before coming into contact with clients. If you have questions and/or concerns while completing this form, a Registered Nurse may assist you.

1. Are you experiencing, or do you have any of the following symptoms? Please circle the appropriate answer.

- Sore Throat — Yes or No
- Rash/vesicles on skin — Yes or No
- Recurrent fever — Yes or No
- Drainage from Eyes, ears, skin lesion — Yes or No
- Nausea, vomiting, or diarrhea — Yes or No
- Night sweats — Yes or No
- Productive cough for more than 3 weeks — Yes or No
- Nonhealing wound — Yes or No
- Swollen nontender lymph nodes — Yes or No

2. Have you ever been told by a physician that you have any of the following conditions?

- Hepatitis A — Yes or No
- Hepatitis B — Yes or No
- Hepatitis C — Yes or No
- Tuberculosis — Yes or No
- Rubella (German measles) — Yes or No
- HIV/AIDS — Yes or No
- Have your traveled outside of the United States in the last 30days? — Yes or No
  If **YES** please indicate _____
- Any other diseases or health problems that — Yes or No
  Your personal care agency employer should be aware of?
  If Yes, (please describe)_____
- Have you traveled outside of the United States in the last 12 months? — Yes or No
  If Yes please indicate where:_____

Depending on the answers to the above questions, the registered nurse (RN) reviewing this document may refer you for a follow-up appointment with your physician, nurse practitioner (NP) or physician's assistant (PA). At this appointment you will receive written documentation that you pose no risk for exposing others to communicable diseases.

I, _____ *acknowledge that the above information is true. To the best of my knowledge,*
PRINT NAME

I do not have any communicable diseases or health problems that will prevent me from providing care to clients.

_____ _____
SIGNATURE of person filling out above Date

ROUTE TO AGENCY REGISTERED NURSE IMMEDIATELY FOR REVIEW
RN referral to physician, NP, PA for further evaluation:

☐**YES** ☐**NO**

_____ _____
PRINT NAME- RN Date

_____ _____
SIGNATURE RN Date

File In Employee Health File