Staff Return To Work Screening Tool

Form to be completed by Charge Nurse for all employees returning to work from Influenza Like Illness.
Completed form to be given to manager.

Staff Member Name:	**YES**	**NO**	**COMMENTS**
1. Within the last 24 hours, have you had any of the following symptoms:			
a. Cough?			
b. Runny nose?			
c. Sore throat?			
d. Chest tightness and/or shortness of breath?			
e. Fever (≥100°F)/chills?			**If Yes, may not return to work.**
f. Muscle/joint pain?			
2. Are you currently taking any medications to reduce fever (IE Tylenol/Motrin/Aspirin)?			**If Yes, may not return to work.**
3. Are you currently taking any antiviral medication for influenza?			Date medication started _____ Name of medication _____

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Temperature: _____ **Date/Time:** _____

DISPOSITION:

WORK: _____ HOME: _____
Date/Time: _____

_____
(**Signature of staff** completing or verifying the form)

Before returning to work staff must feel clinically better AND be afebrile while off fever reducing medication for 24hrs.