



Screening for Communicable Disease

1. Are you having symptoms like:

Fever	<input checked="" type="checkbox"/>	Loose Motion	<input checked="" type="checkbox"/>	Nausea	<input checked="" type="checkbox"/>
Vomiting	<input checked="" type="checkbox"/>	Cough	<input checked="" type="checkbox"/>	Cold	<input checked="" type="checkbox"/>
Skin Rashes	<input checked="" type="checkbox"/>	Headache	<input checked="" type="checkbox"/>	Itching / Redness in eyes	<input checked="" type="checkbox"/>
Breathlessness	<input checked="" type="checkbox"/>				

2. History of contact with any person with known communicable disease : No Yes

If yes, details: _____

3. Are you aware of spread of any such infection in your location : No Yes

If yes, details: _____

4. Recent travel history (last 1 month)

If yes, details: NO

5. Past history of animal bites. Yes No

If yes, details: _____

6. Child hood vaccination Yes No

If yes, details: Not find details available

If any two or more questions are Yes, then follow isolation protocols / protocols for communicable disease

Staff Name: Aji Signature: [Signature] Emp.ID: new Date: 5/10/24 Time: _____