Worker's name: ____ DOB (mm/dd/yyyy): ___ /___ /_____

Organization: ____

State of residence: _____________________________________

Facility name, location: ____

Dates worked (mm/dd/yyyy): ___ /___ /_____ to ___ /___ /_____ Staff role:_________________________

Duties: ____

EXPOSURE ASSESSMENT

(To be completed by the worker after the last work shift. Questions apply to the past 21 days.)

***For healthcare workers in non-E/MTU settings*:**

Provided care to an acutely ill patient later diagnosed with Ebola disease or MVD? ☐ YES ☐ NO

Provided care to a patient who died of illness compatible with Ebola disease or MVD* but not confirmed as Ebola disease or MVD ☐ YES ☐ NO

Exposed to body of person who died of Ebola disease or MVD or compatible illness*? ☐ YES ☐ NO

***For laboratory workers who handled or processed patient specimens*:**

Processed lab specimens of a patient later diagnosed with Ebola disease or MVD? ☐ YES ☐ NO

Processed specimens of a patient who died of compatible illness*? ☐ YES ☐ NO

***For non-healthcare workers*:**

Had direct contact with an acutely ill patient later diagnosed with Ebola disease or MVD? ☐ YES ☐ NO

Had direct contact with a patient who died of a compatible illness*? ☐ YES ☐ NO

Exposed to body of a person who died of Ebola disease or MVD or compatible illness*? ☐ YES ☐ NO

Worker should complete the section below if answers YES to any question in this section.

**Compatible illness includes body temperature ≥100.4°F or 38°C or subjective fever, or signs/symptoms including severe headache, fatigue, muscle pain, vomiting, diarrhea, abdominal pain, or unexplained hemorrhage.*

Exposure Incidents (Complete this section if answered YES to any question above.)

PPE worn during incident (circle all that apply):
none gloves facemask face shield/eye protection gown

Describe the incident: ____

____

____

____

Date of incident (mm/dd/yyyy): __ /__ /_____

Action taken: ____

END OF EXPOSURE ASSESSMENT

HEALTH ASSESSMENT (To be completed by Medical Supervisor within 24-48 hours of worker's departure)

Worker's name: ____ DOB (mm/dd/yyyy): ___ /___ /_____

Date assessment completed: ___ /___ /_____ Time: _____________

Name of person performing the assessment: _________________________________ Title: ________________

Signature: ____

Ebola vaccination status

Ebola vaccine received: ☐ YES ☐ NO

If vaccinated against Ebola virus, specify: ☐ Pre-exposure ☐ Post-exposure

Date of vaccination: ___ /___ /_____ Name of Vaccine: ____

Date of vaccination: ___ /___ /_____ Name of Vaccine: ____

Clinical Assessment

Appears well: ☐ YES ☐ NO – specify: ____

____

Oral temperature measurement: ____________ °C/°F

Signs and symptoms, medication history

Signs/symptoms in the past 48 hours: ☐ None reported

☐ Fever – if YES, T-max: _______ °C/°F Method: ________________ Date: ___ /___ /____ Time: ______

☐ Fatigue ☐ Weakness ☐ Muscle pain ☐ Vomiting ☐ Diarrhea ☐ Chest Pain

☐ Abdominal pain ☐ Headache ☐ Joint pain ☐ Sore throat ☐ Difficulty breathing

☐ Unexplained bruising/bleeding

Earliest symptom onset Date: ___ /___ /_____ Time: _________

Use of antipyretic medication(s) <u>in past 12 hours</u>: ☐ None

Name of antipyretic: ___________________ Dose: _______ Time: ______ Purpose: ____________

Name of antipyretic: ___________________ Dose: _______ Time: ______ Purpose: _____________

Was malaria prophylaxis taken as prescribed: ☐ YES ☐ NO

Name of antimalarial: _______________________________

END OF HEALTH ASSESSMENT