Texas Health Resources

Health Care Worker Influenza Monitoring Form

Name: _____ Employee ID #: _____

Job Title: _____ Department: _____

Date/s of exposure to known Influenza patient: _____

Type of contact with patient, patient environment, or virus: _____

Was personal protective equipment (PPE) used? ☐ No ☐ Yes

If yes, list PPE used: ☐Gown ☐Gloves ☐Face Shield ☐Shoe Covers
☐Particulate Respirator ☐Surgical Mask ☐Eye Protection

Please check your temperature daily before reporting for work and monitor yourself for any of the following influenza-like illness symptoms (SX):

Fever 100.4 or >
Acute onset of respiratory illness
GI symptoms (diarrhea, vomiting, abdominal pain)
Cough
Sore throat
Muscle or joint pain

Day 1	Day 2	Day 3	Day 4	Day 5
Date:	Date:	Date:	Date:	Date:
AM Temp:	AM Temp:	AM Temp:	AM Temp:	AM Temp:
PM Temp:	PM Temp:	PM Temp:	PM Temp:	PM Temp:
SX: No☐ Yes☐	SX: No☐ Yes☐	SX: No☐ Yes☐	SX: No☐ Yes☐	SX: No☐ Yes☐

Day 6	Day 7	Day 8	Day 9	Day 10
Date:	Date:	Date:	Date:	Date:
AM Temp:	AM Temp:	AM Temp:	AM Temp:	AM Temp:
PM Temp:	PM Temp:	PM Temp:	PM Temp:	PM Temp:
SX: No☐ Yes☐	SX: No☐ Yes☐	SX: No☐ Yes☐	SX: No☐ Yes☐	SX: No☐ Yes☐

Day 11	Day 12	Day 13	Day 14	Day 15
Date:	Date:	Date:	Date:	Date:
AM Temp:	AM Temp:	AM Temp:	AM Temp:	AM Temp:
PM Temp:	PM Temp:	PM Temp:	PM Temp:	PM Temp:
SX: No☐ Yes☐	SX: No☐ Yes☐	SX: No☐ Yes☐	SX: No☐ Yes☐	SX: No☐ Yes☐

Day 21	Day 22	Day 23	Day 24	Day 25
Date:	Date:	Date:	Date:	Date:
AM Temp:	AM Temp:	AM Temp:	AM Temp:	AM Temp:
PM Temp:	PM Temp:	PM Temp:	PM Temp:	PM Temp:
SX: No☐ Yes☐	SX: No☐ Yes☐	SX: No☐ Yes☐	SX: No☐ Yes☐	SX: No☐ Yes☐

If any symptoms of influenza-like illness occur, immediately limit your interactions with others, exclude yourself from public areas, and notify the Employee Health Nurse: _____ at Phone number: _____ at your hospital immediately.

Source: Arlington (TX) Memorial Hospital.