The Doorways
Guest Health Screening Questionnaire

Please answer YES or NO to all of the questions below.
Have you had any of the following:

YES ☐ NO ☐ Fever higher than 100.4° F (38.0° C) in the past 2 days?
YES ☐ NO ☐ Vomiting in the past 2 days?
YES ☐ NO ☐ Stiff neck or headache with a fever in the past 2 days?
YES ☐ NO ☐ Diarrhea in the past 2 days?
YES ☐ NO ☐ Current skin lesions that are “weepy” (fluid or pus filled)?
YES ☐ NO ☐ ANY current skin rash?
YES ☐ NO ☐ Current cold or flu symptoms (runny nose, cough, congestion)?
YES ☐ NO ☐ Exposure to Tuberculosis (TB) in the past 2 months?
YES ☐ NO ☐ Exposure to any of the following within the past 3 weeks:
☐ Chickenpox
☐ Household member with head lice
☐ Measles
☐ Mumps
☐ Whooping Cough

Contact the Guest Relations Manager to discuss any “Yes” answer above, prior to allowing entry

Chickenpox Status:
YES ☐ NO ☐ Have you had chickenpox or shingles before?
YES ☐ NO ☐ Have you been vaccinated against chickenpox (varicella)?

Vaccine Questions
YES ☐ NO ☐ Have you received the Chickenpox vaccine within the last 21 days?
YES ☐ NO ☐ Have you received the MMR vaccine in the last 14 days?
YES ☐ NO ☐ Have you received the Polio vaccine within the last 14 days?
YES ☐ NO ☐ Have you received the Rotavirus vaccine within the last 14 days?
YES ☐ NO ☐ Have you received the Typhoid vaccine within the last 14 days?
YES ☐ NO ☐ Have you received the Flu-Mist vaccine within the last 14 days?

Name:________________________________________       Date:_____________
Email:__________________________________________________

The Society for Healthcare Epidemiology of America guideline for Infection Prevention and Control for Pediatric Patients and Their Families

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