Northwestern Medicine®

OBSERVER CLEARANCE FORM

(Only for observations that are ONE day in duration)

Name: _____ **Birth Date:** _____ **Today's Date:** _____

Department: _____ **Hours that will be observing today:** _____

Email Address _____ **Personal Phone:** _____

Person shadowing _____

SYMPTOM SCREEN

Please answer each of the following questions:

	YES	NO	UNKNOWN	CLINICIAN USE:
Do you have a fever of 100°F or greater?	☐	☐	☐	
Do you have nausea and/or vomiting and/or diarrhea?	☐	☐	☐	
Do you have any stomach pain?	☐	☐	☐	
Do you have a sore throat?	☐	☐	☐	
Do you have any muscle aches or feel sick?	☐	☐	☐	
Do you have a runny nose?	☐	☐	☐	
Do you have a headache?	☐	☐	☐	
Do you have a rash?	☐	☐	☐	
Do you have any open sores?	☐	☐	☐	
Do you have a prolonged cough with production of sputum or blood?	☐	☐	☐	
Do you have chest pain or shortness of breath?	☐	☐	☐	
Do you have Involuntary weight loss or a loss of appetite?	☐	☐	☐	
Do you have night sweats, or easy fatigability?	☐	☐	☐	
Do you have knowledge of a communicable disease?	☐	☐	☐	

When did your symptoms start? Date: _____ Time: _____

I have answered the questions above honestly and to the best of my knowledge.

_____ _____

Patient Signature Date

OFFICE USE ONLY

Temperature: _____ Oral or Tympanic

*If temperature is greater than 100°F, you may not participate in observation

_____ _____ _____

Provider Name Provider Signature Date of Review