PUBLIC HEALTH DIVISION
Acute and Communicable Disease Prevention

Please complete the health assessment form below for each day until 14 days after your last exposure to *Francisella tularensis* (Tularemia). If you develop fever or other listed symptoms within 14 days of your last exposure, contact your occupational health personnel immediately.

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Last name: _____ First name: _____ Date of birth: _____/_____/_____

Laboratory: _____ Work Phone: _____ Home phone: _____

| | Date ___/___/___ Circle one | Date ___/___/___ Circle one | Date ___/___/___ Circle one | Date ___/___/___ Circle one | Date ___/___/___ Circle one | Date ___/___/___ Circle one | Date ___/___/___ Circle one |
|---|---|---|---|---|---|---|---|
| Fever | Yes No Temp:____ F | Yes No Temp:____ F | Yes No Temp:____ F | Yes No Temp:____ F | Yes No Temp:____ F | Yes No Temp:____ F | Yes No Temp:____ F |
| Chills | Yes No | Yes No | Yes No | Yes No | Yes No | Yes No | Yes No |
| Headache | Yes No | Yes No | Yes No | Yes No | Yes No | Yes No | Yes No |
| Body aches | Yes No | Yes No | Yes No | Yes No | Yes No | Yes No | Yes No |
| | Date ___/___/___ Circle one | Date ___/___/___ Circle one | Date ___/___/___ Circle one | Date ___/___/___ Circle one | Date ___/___/___ Circle one | Date ___/___/___ Circle one | Date ___/___/___ Circle one |
| Fever | Yes No Temp:____ F | Yes No Temp:____ F | Yes No Temp:____ F | Yes No Temp:____ F | Yes No Temp:____ F | Yes No Temp:____ F | Yes No Temp:____ F |
| Chills | Yes No | Yes No | Yes No | Yes No | Yes No | Yes No | Yes No |
| Headache | Yes No | Yes No | Yes No | Yes No | Yes No | Yes No | Yes No |
| Body aches | Yes No | Yes No | Yes No | Yes No | Yes No | Yes No | Yes No |