ILLNESS SURVEILLANCE FORM

Facility Name: _____ Phone #: _____ Director:_____

Name	Gender	Age	Class/Group	Onset Date/Time	Symptoms*	Symptom Duration (Hours)	Treatment/Action†	Date & Time Returned to Group Care

*** Symptoms:** **V** = Vomiting **A** = Abdominal Cramps **M** = Muscle Aches **D** = Diarrhea **N** = Nausea
H = Headache **R** = Rash **F** = Fever (provide temperature) **C** = Chills **O** = Other (please list)

† Treatment/Action: Enter specific treatment or action provided (first aid, administered medication), sent home, sent back to group care, excluded for 48 hours, isolated, hospitalized, etc.

Tri-County Health Department