ILLNESS SURVEILLANCE FORM

**Facility Name:** _______________________________  **Phone #:** _____________________________  **Director:** ____________________________________

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

† **Treatment/Action:** Enter specific treatment or action provided (not allowed to attend, first aid, administered medication, sent home, sent back to group care, excluded for 48 hours, isolated, quarantined, etc.)

**Ill child logs** will need to be maintained by your facility for 2 months prior. If you see an increase in incidences of vomiting and diarrhea or suspect COVID-19, it is very important that you contact Tri-County Health Department to go over measures to help prevent it from spreading further.

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<tr>
<th>Name</th>
<th>Gender</th>
<th>Age</th>
<th>Class/Group</th>
<th>Onset Date/Time</th>
<th>Symptoms*</th>
<th>Symptom Duration (Hours)</th>
<th>Treatment/Action†</th>
<th>Hospitalized?</th>
<th>Date and Time Returned to Care</th>
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**Rev. May 2020**

Handout available at: www.tchd.org/242/Child-Care