Child Care/School Line List 2011

created 8/13/2009 Epidemiology Program MMB

Date: _____

Facility Name: _____

Reporter: _____

Phone number: _____

Epidemiology Program fax: **595-6268**

Please put a check mark ✓by all that applies

Last Name, First Name	Parent/Guardian name and phone number	Doctor name & phone number	DOB	M/F	Grade	Room # or Activity (band, football etc)	Onset Date	Fever	Chills	Cough	Sore throat	Congestion	Headache	Runny nose	Body/Muscle Aches	Nausea	Vomiting	Blood in Stool	Diarrhea	Abdominal Cramps	Trouble breathing	Rash	Lice/Scabies put L/S	Fully Vaccinated?	Testing for disease?	**Outcomes** Seen by clinician	Died	Hospitalized	Duration of Illness in Hours

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