

Dedicated to protecting and improving the health and environment of the people of Colorado

ILLNESS SURVEILLANCE FORM

Child Care Facility Name:		Contact Person:			Phone #:		
Name	AGE	CLASS/ GROUP	Onset Date/Time	Symptoms*	SYMPTOM DURATION (HOURS)	TREATMENT/ACTION†	DATE & TIME RETURNED TO GROUP CARE
	M. M. W.						
Symptoms: V = Vomiting A = Abdominal Cramps D = Diarrhea H = Headache F = Fever (provide temperature) C = Chills					M = Muscle AchesR = RashO = Other (please list)		
Treatment/Ac solated, hospita	tion: Specific treat			ered medication, etc.), ser		oup care, excluded for 48 h	ours,
Reviewed by Person in Charge:						Date:	