



COLORADO

Department of Public Health & Environment

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

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

† Treatment/Action: Specific treatment provided (first aide, administered medication, etc.), sent home, sent back to group care, excluded for 48 hours, isolated, hospitalized, etc.

Reviewed by Person in Charge: _____

Date: _____