



Health Department
1-800-777-9613, Fax (905) 666-1833

CHILD CARE CENTRE OUTBREAK LINE LISTING FORM

Outbreak No.: 2230 / /

Date: _____

Name: _____

Address: _____

Phone No.: _____ Fax No.: _____

Case Definition: _____

Children Staff

→ **Note: List staff and children on separate forms**

Case Number (sequentially)	Name	Gender (M/F)	Date of Birth (dd/mm/yy)	Room #	Date of Onset of Symptoms (d/m)	SYMPTOMS																	Date Returned to Child Care Centre (d/m)	Symptoms Resolved (y / n)	Specimens			Comments/ Diagnosis														
						ENTERIC					RESPIRATORY														f-fecal	s-saliva	n-nasal															
						nausea	vomiting (record # of episodes)	diarrhea (record # of episodes)	bloody stool	abdominal cramps	headache	fever (°C) or (°F)	chills	dry cough (new)	productive cough (new)	runny nose	nasal congestion / stuffy nose	sore throat	hoarseness / difficult swallowing	myalgia (aching bones & joints)	malaise	headache	other (please specify)	other																		