



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 **A** = Abdominal Cramps **M** = Muscle Aches
 D = Diarrhea **H** = Headache **R** = Rash
 F = Fever (provide temperature) **C** = Chills **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: _____