COLORADO
Department of Public Health & Environment

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:_____