Influenza and Respiratory Outbreak Line List for Non-Healthcare Facilities

☐ Students ☐ Staff ☐ Residents

Facility Name ____________ **Contact Person:** ____________ **Contact Phone:** ____________ **Contact Email:** ____________

Outbreak Number ____________ **Total # students/staff/residents in affected classroom(s)/unit(s)** ____________ Students/Residents ____________ Staff **Date:** ____________

Student/Staff/Resident Identification					Location		Vaccination Status		Illness Description										Diagnostics							Outcome		
Case No.	First Name	Last Name	Age or Date of Birth	Gender	Room/Office/Unit #	Grade	Influenza vaccination? (Y/N/U)	If yes, vaccination date	Date of Illness Onset	Symptoms from CalCONNECT*	Fever (Y/N) or highest temparature (°F)†	Cough (Y/N)	Myalgia/Body Aches (Y/N)	Chills (Y/N)	Sore Throat (Y/N)	Runny Nose (Y/N)	Other (Y/N)	Date recovered/returned to school	Doctor Visit (Y/N)	Specimen Collected (Y/N)	Diagnosis/Lab Result	Antivirals (Y/N)	Antivirals Date Started/Date Ended	Antibiotics (Y/N)	Antibiotics Date Started/Date Ended	Final Diagnosis Influenza/Pneumonia/Other	Hospitalized (Y/N), if yes # of days	Died (Y/N, If yes, date)
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* Symptoms collected by COT during pre-OB investigation. † Fever is self-reported or highest temperature measured oral, under armpit or rectal

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