CHILD CARE SURVEILLANCE FORM

Facility Name: _____ Address: _____

Contact Name: _____ Telephone: _____ E-mail: _____

IDENTIFICATION					SYMPTOMS																						CONCLUSION					
Case number	Child (C) / Employee (E)	Name	Groupe / Cohort	Onset of symptoms	Fever	Chills	Cough	Shortness of breath	Decrease or loss of taste or smell	Muscle aches	Joint pain	Extreme tiredness	Runny nose	Congested nose	Sore throat	Difficulty swallowing	Headaches	Nausea	Abdominal pain	Vomiting – Specify 1 or + (episodes in 24h)	Diarrhea - Specify 1 or + (episodes in 24h)	Difficulty breathing	Wheezing	Sneezing	Loss of appetite	Hoarseness	Feeling unwell (malaise)	Isolation - 5 days / 10 days	Consult health care provider	COVID-19 testing - PRC (P) / Rapid (R)	Test result	Return date	Comments or complications

Please send report by email at ccc@eohu.ca when you have 3 individuals, from same cohort, within 4 days showing at least 2 symptoms, so the EOHU can offer support to evaluate a possible outbreak.

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