simcoe muskoka
DISTRICT HEALTH UNIT

Name of Facility: ____________________ Date Outbreak Declared: ____________

Outbreak Number: ____________________

Case Identification						Symptoms															Specimen Collection				Resolution	
Case # (sequentially)	Name (LAST NAME, first name)	Sex (M, F, X)	Date of Birth (yy/mm/dd)	Parent contact & Phone #	Cabin Name or #	Onset date of first symptom (yy/mm/dd)	Abnormal temperature (°C)	Cough (new)	Runny nose /congested nose	Sore throat	Hoarseness / difficulty swallowing	Muscle aches/pain	General feeling of unwell (malaise)	Headache	Decreased appetite	Decrease or loss of taste or smell	Extreme tiredness	Nausea, vomiting and/or diarrhea	Shortness of breath	Other - please specify	Swab date (yy/mm/dd)	Result (list positive, pathogen, test type)	Hospitalized (y/n)	Comments (recent canoe trip, gone home, moving cabins etc.)	Date resolved (yy/mm/dd)	Date returned to camp/cabin (yy/mm/dd)
1																										
2																										
3																										
4																										