**REPORT FORM: OUTBREAK OF INFLUENZA-LIKE ILLNESS (ILI) OR INFLUENZA IN A SCHOOL**

MDH Outbreak #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of report: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ Jurisdiction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LHD contact person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Facility contact person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| * Elementary Middle  High  K-8 K-12 | * Public  Private |
| * Special needs  Vocational  Other:\_\_\_\_\_\_\_\_\_\_ | |
| Number of students enrolled at the school: | Number of staff: |

School Description:

Date the outbreak was first recognized: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_

Absenteeism: Day of report (# or %): \_\_\_\_\_\_\_\_\_\_\_\_ Baseline (# or %):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of health room visits on day of report: Total: \_\_\_\_\_\_\_\_\_\_\_\_\_ For ILI: \_\_\_\_\_\_\_\_\_\_

Special populations affected or clusters identified? YES NO

* Specify grades/class, or defined population (e.g., team, club): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agent identified:  Yes  No  Unknown  Clinical diagnosis made by healthcare provider?

If Yes:  Influenza A  Influenza B  Type unknown or  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was school or class dismissed/closed for any days? YES NO

* If yes, on what date? \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ For how many days? \_\_\_\_\_\_\_\_\_

Date outbreak ended\*: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_

**Optional information:**

**STUDENTS: STAFF:**

# of cases (TOTAL)       # of cases (TOTAL)

# with lab-confirmed influenza       # with lab-confirmed influenza

# with ILI       # with ILI

# of hospital admissions       # of hospital admissions

List the symptoms and their frequency experienced by cases in this outbreak: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_