ACUTE GASTROINTESTINAL ILLNESS REPORT FORM

TAZEWELL COUNTY **CITY** _____ **DATE** _____

PATIENT IDENTIFICATION				ILLNESS DESCRIPTION							ILLNESS OUTCOME
NAME	**Age**	**Gender**	**Classroom or Grade**	**Onset Date**	**Highest Temp**	**Diarrhea (Y/N)**	**Vomiting (Y/N)**	**Nausea (Y/N)**	**Abdominal Cramps (Y/N)**	**Chills (Y/N)**	**Hospitalized (Y/N)**

Email to schoolreporting@tchd.net or fax to 309-925-2038

REPORTED BY (Name) _____ FACILITY/SCHOOL _____

Aug-20