ACUTE RESPIRATORY ILLNESS OUTBREAK FOLLOW-UP

Name of facility:	
City:	County:
Health Department Jurisdiction:	

Laboratory confirmed diagnosis (indicate all that pertain)

Influenza A ____ Influenza B _____ Parainfluenza ____
Adenovirus ____ RSV ____ Human Metapneumovirus _____
Rhinovirus ____ Other (specify) _____

Onset date of first respiratory illness _____

Onset date of last respiratory illness _____

	Number exposed	Number ill	Number hospitalized	Number of deaths
Residents				
Staff				

Complete section below for suspected or confirmed influenza outbreaks only.

Influenza Prophylaxis

Was an antiviral administered to exposed individuals? Y___ N ____

If yes, please indicate product: _____

Number of residents who received antiviral prophylaxis _____

Number of staff who received antiviral prophylaxis _____

Vaccination	Total number at facility	Total number that received **Influenza** vaccine	Number ill that received **Influenza** vaccine
Residents			
Staff			

With what influenza vaccine were residents vaccinated? If response is "yes" to more than one vaccine specify the percentage of total vaccinated for each

				Date(s) administered
Fluzone	Y	N	_____%	_____
Fluzone high-dose	Y	N	_____%	_____
Fluzone intradermal	Y	N	_____%	_____
Fluvirin	Y	N	_____%	_____
Fluarix	Y	N	_____%	_____
Flulaval	Y	N	_____%	_____
FluMist	Y	N	_____%	_____
Unknown	Y	N	_____%	_____

Please return this form by fax to PHMDC ACD Admin at 608-266-4858.