Facility Name:

Page ____of____

No.	Name (last, first)	Age	Sex	Resident or Staff	Unit	Floor	Room	Date of onset	Diarrhea (Y/N)?	Bloody Diarrhea (Y/N)?	Vomiting (Y/N)?	Fever (Y/N)?	Cramps (Y/N)?	Date of last symptoms	Seen HCP (Y/N)?	Hospitalized (Y/N)?	Stool sample (Y/N)?	If yes, date	If yes, result

Please fax back daily to:
Snohomish Health District Communicable Disease
Fax: 425-339-8706