GASTROENTERITIS SURVEILLANCE FORM (For Employees)

**Name of Facility, Date_____________________________________________________________

Name:_____________________________________________Age:_____________Sex:___________
Address:___________________________________________________________________________
_________________________________________________ Phone:___________________________

Type of Work:_____________________________________________________________________
Wing/Floor of Work:_________________________________________________________________
Working Hours:_____________________________________________________________________

Do you work in any other facilities?____ If yes, where:__________________________________

**Have you developed diarrhea and/or vomiting since _________________________________?(Date)
___Yes  ___No   If yes, what date did the diarrhea and/or vomiting start?________________________

Please check if you have or had any of these symptoms:

Yes    No

- Diarrhea _____ _____
- Vomiting _____ _____
- Abdominal Cramps _____ _____
- Nausea _____ _____
- Fever _____ _____ How high?____
- Blood in Stools _____ _____
- Headache _____ _____
- Chills _____ _____
- Muscle ache _____ _____
- Other _________________________

How long did your diarrhea and/or vomiting last?___________days

Were you seen by a physician for the above symptoms? Yes____ No____
If yes, by: Name:____________________________________________Phone:___________________

Did you take this medicine?  Yes______  No______  If yes, list:_____________________________

Were you hospitalized for this problem? Yes_____  No_____

If seen by a physician or hospitalized, was a stool culture taken? Yes____ No____

**Note: Complete Name of Facility and Dates prior to distributing this form