ACUTE RESPIRATORY ILLNESS OUTBREAK FOLLOW-UP

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

Laboratory confirmed diagnosis of (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 to Marathon County Health Department by either submitting with final line list using the LTCF Online Reporting Tool or fax to 715-261-1901.