



NAME OF INDEX CASE		DATE COMPLETED (YYYY / MM / DD)			COMPLETED BY		PAGE NO.
	CONTACT	CONTACT	CONTACT	CONTACT	CONTACT	CONTACT	
NAME							
DOB / (AGE)							
GENDER	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	
PARENT'S NAMES (IF UNDER 18)							
PHONE: HOME BUSINESS							
ADDRESS							
DOCTOR'S NAME AND PHONE NO.							
RELATIONSHIP TO CASE (EG., FAMILY, DAYCARE, PRESCHOOL)							
PREGNANT / EDC							
DATE OF CONTACT WITH CASE							
IMMUNIZATION STATUS (# OF DOSES)							
OCCUPATION / SCHOOL / DAY- CARE / PRE- SCHOOL							
SIGNS & SYMPTOMS							
DATE OF SWAB (IF DONE) AND RESULTS							
PROPHYLAXIS RECOMMENDED	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
PRESCRIBED ANTIBIOTIC DATE:	<input type="checkbox"/> YES <input type="checkbox"/> NO YYYY MM DD	<input type="checkbox"/> YES <input type="checkbox"/> NO YYYY MM DD	<input type="checkbox"/> YES <input type="checkbox"/> NO YYYY MM DD	<input type="checkbox"/> YES <input type="checkbox"/> NO YYYY MM DD	<input type="checkbox"/> YES <input type="checkbox"/> NO YYYY MM DD	<input type="checkbox"/> YES <input type="checkbox"/> NO YYYY MM DD	
OTHER							