

DAYCARE/SCHOOL COMMUNICABLE DISEASE MONTHLY REPORT

MONTH: _____ YEAR: _____ NAME OF DAYCARE/SCHOOL : _____

Please check here if nothing to report

Date of absence	Child Name	Parent Name	Telephone Number (Required)	Date of Birth yy/mm/dd	INFECTIOUS DISEASE		HEALTH UNIT NOTIFIED	
					Suspected: Please specify disease.	Diagnosed: Please specify disease.	By Phone (Date)	By this Report (✓)

NOTE:

- Enter the parent's name ONLY if the family name is different from that of the child.
- Measles, Mumps, German Measles, Whooping Cough and Meningitis are to be reported by telephone as soon as possible. Prompt follow up is of the utmost importance.

Principal/delegate: _____ Date: _____

Fax or email completed report by the 10th day of the following month to:

Communicable Disease Control Program
 Telephone: (705) 474-1400 or 1-800-563-2808
 FAX: (705) 474-2809
 Email: dalebr@nbdhu.on.ca *Note: e-copy of this form available upon request*

