BRANT COUNTY
HEALTH UNIT

194 Terrace Hill Street
Brantford, ON N3R 1G7
519-753-4937

www.bchu.org

Illness Notification Form

Date Reported:	
Child Care Centre:	**Reporting Staff Name:** **Contact Information:**
Case's Details	
Last Name:	**First Name:**
DOB:	**Address**:
Parents/Guardians Name (first and last) *(if applicable)*	**Contact Information:**
Underlying Medical Conditions:	**Known Allergies:**
Known COVID-19 Exposure: provide details in space below	

Signs and Symptoms: (Check all applicable)			
Date of symptom(s) onset:			
☐Fever	☐New or worsening cough	☐Shortness of breath	☐Sore throat
☐New olfactory or taste disorder	☐Nausea	☐Vomiting	☐Diarrhea
☐Abdominal pain	☐Runny nose or nasal congestion (unrelated to seasonal allergies or postnasal drip, etc.)	☐Unexplained fatigue	☐Conjunctivitis
☐Lethargy	☐Difficulty feeding in infants	☐Other:	

Actions Taken (check all that apply)	
☐Health unit notified of illness	☐Child isolated and sent home ☐Staff sent home
☐Medical assessment recommended	
☐ Isolation room disinfected	☐ All items used by ill individual cleaned and disinfected

Note: Follow-up section to be filled out when update is received from parents/guardians.

Clear Form

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Follow-Up		
Date:	**Reporting Staff Name:** **Contact Information:**	
☐Physician's assessment received	**Actions**	☐Doctor's note attached to file ☐Case is at least 24 hours symptoms free **Expected date of retur**n:
☐Testing recommended	**Actions**	☐Health unit notified ☐Cohort self-monitoring ☐Cohort room closed ☐Cohort self-isolating ☐Room cleaned & disinfected ☐Communication to parents/guardians ☐Cohort information provided to health unit ☐Occurrence reported to MOE
Cohort Details		
Please provide the names (first name and initial of the last name) of everyone in the cohort and/or who may have had contact with the cohort:		
Additional Notes		