New Jersey Department of Health
Communicable Disease Service

OUTBREAK REPORT FOR CHILD CARE, SCHOOL AND CAMP SETTINGS

Name of Lead Public Health Agency	County	E#

Date Outbreak Reported to Local Health Department (LHD):	Date Reported to State Health Department

BRIEF SUMMARY

Summary should include key facts that describe what happened. Some information to include: date and place of outbreak, key statistics (number exposed, number of cases, number hospitalized, number of deaths, average duration of illness), causative or suspect organism, control measures and recommendations.

FACILITY INFORMATION

A. FACILITY DESCRIPTION

Name of Facility	Telephone Number
Street Address	County
City/Town	Zip Code
Name of Contact Person	Contact Telephone Number

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FACILITY INFORMATION

A. FACILITY DESCRIPTION

Type of Facility/Population *(check all that apply)*:

☐ Child Care
☐ Pre-School
☐ School/Grade Levels ______________
☐ College/University
☐ Day Camp
☐ Residential Camp

Total Number of:

Students: ______________
Children: ______________
Staff: ______________

State the number of buildings, wings, units, cabins, floors, etc. that make up the facility. Include number and describe population per area (e.g., age group, grade, student, staff, etc.).

B. OUTBREAK DEMOGRAPHICS

Students:	Total Number (Census):	# Ill:	# Hospitalized:	# Visited ER:	# Visited HCP:	# Deaths:
Staff: *	Total Number:	# Ill:	# Hospitalized:	# Visited ER:	# Visited HCP:	# Deaths:

** Staff includes volunteers, teachers, counselors, housekeeping, recreational, cafeteria, health and administrative activities.*

Gender (estimated percent of the primary cases): Male: __________ **%** Female: __________ **%**

Specify location of outbreak within physical structure described above. If requested, Attach floor plan and identify affected area(s):

Illness Onset Date – FIRST Case			Illness Onset Date – LAST Case		
Incubation Period			**Duration of Illness (e.g., 24-48 hours, 1-5 days)**		
Shortest		☐ Minutes ☐ Hours ☐ Days	Shortest		☐ Minutes ☐ Hours ☐ Days
Median		☐ Minutes ☐ Hours ☐ Days	Median		☐ Minutes ☐ Hours ☐ Days
Longest		☐ Minutes ☐ Hours ☐ Days	Longest		☐ Minutes ☐ Hours ☐ Days
Total Number of Cases for Whom Information is Available:			Total Number of Cases for Whom Information is Available:		
☐ Unknown Incubation Period			☐ Unknown Duration of Illness		

Type of Illness

☐ GI ☐ Respiratory/ILI ☐ Influenza ☐ Rash Illness *(specify if known)*: ______________________________
☐ Other *(specify)*: ____

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B. OUTBREAK DEMOGRAPHICS

Signs and Symptoms *(check all that apply and document % of cases for each)*:

X	%	Sign or Symptom	X	%	Sign or Symptom	X	%	Sign or Symptom
☐	______	Abdominal cramps	☐	______	Fatigue	☐	______	Nausea
☐	______	Bloody stool	☐	______	Fever	☐	______	Rash
☐	______	Chills	☐	______	Headache	☐	______	Sore throat
☐	______	Cough	☐	______	HUS	☐	______	Vomiting
☐	______	Diarrhea	☐	______	Nasal Congestion			
		Other *(Specify)*:						
☐	______	______________________						
☐	______	______________________						
☐	______	______________________						

OUTBREAK INVESTIGATION

A. INVESTIGATION TEAM

Representative's Position	Name/Title	Telephone Number
Facility		
______________________	______________________	______________
______________________	______________________	______________
Local Health		
______________________	______________________	______________
______________________	______________________	______________
NJDOH		
______________________	______________________	______________
______________________	______________________	______________
Other *(Specify)*		
______________________	______________________	______________
______________________	______________________	______________

B. OUTBREAK CASE DEFINITION

C. MODE OF TRANSMISSION

☐ Foodborne ☐ Person to Person ☐ Waterborne ☐ No Source Identified

☐ Other *(specify)*: ______________________________

D. LABORATORY TESTING

☐ No Specimens Obtained	Number of Specimens Tested	Number of Specimens Tested Positive

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(Continued)

D. LABORATORY TESTING

Agent(s) Detected:

E. CONSULTATION/INVESTIGATION: TYPE AND FINDINGS

Health Officer: On-site evaluation? ☐ No ☐ Yes

Name: ______________________________

Public Health Nurse: On-site evaluation? ☐ No ☐ Yes

Name: ______________________________

Registered Environmental Health Specialist: On-site evaluation? ☐ No ☐ Yes
If Yes, please attach report.

Name: ______________________________

Other *(Specify)*:

____

CONTROL MEASURES

Refer to control measures section of outbreak guidance document http://www.nj.gov/health/cd/outbreaks.shtml. Complete and attach section to this report.

DOCUMENTATION

Documents Attached to this Outbreak Summary *(check all that apply)*:

- ☐ Epidemic Curve
- ☐ REHS Facility Inspection Report
- ☐ Lab Test Reports *(required if available)*
- ☐ Waterborne Outbreak Summary Form
- ☐ Control Measures *(required)*
- ☐ Line-Listing *(required)*
- ☐ Floor Plan
- ☐ Foodborne Outbreak Summary Form
- ☐ Other *(specify)*: ______________________________

OUTCOME

Date Outbreak Resolved (i.e., control measures lifted):

Recommendations for Future Actions

- ☐ Adhere to Timely Reporting
- ☐ Revise Protocol
- ☐ Develop New Protocol
- ☐ Change Product Use
- ☐ Reinforce Exclusion

Other *(Please describe)*:

COMPLETED BY

Name: ______________________________ Title: ______________________________

Agency: ______________________________

Phone: ______________________________ Fax: ______________________________

Email: ______________________________