

Acute Respiratory Infection and Influenza Surveillance Form

Criteria for patient selection and testing

- symptom onset within 4 days
- any two of the following
 - o rhinorrhea
 - o nasal congestion
 - o sneezing
 - o sore throat
 - o cough
 - o fever

School ID: 4K P N B R M H

Participant ID: _____

Age: _____

Date of Collection: _____

Oregon Child Absenteeism due to Respiratory Disease Study

Days between illness onset and today's visit: ____ days

Exposure to a similar illness 1-3 days prior to ARI onset? Yes No

Likely Source: Classmate Friend Family Member (Adult / Sibling) Other: _____

Household Member (circle if living in household, check box if ill with similar ARI):

- | | | | |
|---|---|--|--|
| Grandmother <input type="checkbox"/> | Grandfather <input type="checkbox"/> | Mother (<i>Female Guardian</i>) <input type="checkbox"/> | Father (<i>Male Guardian</i>) <input type="checkbox"/> |
| O/Y Sibling #1 <input type="checkbox"/> | O/Y Sibling #2 <input type="checkbox"/> | O/Y Sibling #3 <input type="checkbox"/> | Other Adult: _____ <input type="checkbox"/> |
| O/Y Sibling #4 <input type="checkbox"/> | O/Y Sibling #5 <input type="checkbox"/> | O/Y Sibling #6 <input type="checkbox"/> | Other Child: _____ <input type="checkbox"/> |

Recent Travel? Yes No Recent Exposure to Farm Animals? Yes No

Severity of Illness (circle): Mild Moderate Severe

Race: White Am Indian or Ak Native Asian Black Native Hawaiian or Other Pacific Islander

Ethnicity: Hispanic Non-Hispanic

Measured Temperature ____ °F Antipyretic use within the last 6 hours? Yes No

Symptoms (circle all that are present):

- | | | | | | |
|----------|----------|----------------|------------------|----------------|--------------|
| Fever | Chills | Cough | Wheezing | Runny Nose | Sore Throat |
| Malaise | Myalgia | Arthralgia | Nasal Congestion | Headache | Ear Pain |
| Anorexia | Vomiting | Abdominal Pain | Diarrhea | Conjunctivitis | Other: _____ |

Influenza antiviral treatment for this illness prior to this visit? Yes No

Seasonal influenza vaccine prior to this illness? Yes No

Visit to health care provider for this illness prior to home visit? Yes (specify when _____) No

Visit to health care provider planned in next few days? Yes (specify when _____) No

Indicate Specimen Type(s) for PCR testing: nasopharynx posterior pharynx

----- ITEMS BELOW THIS LINE FOR LABORATORY ONLY -----

Sofia Result: flu A flu B both negative invalid

Sample Code: ORCHARDS - ____ - ____ - ____
site week staff sample