

Lab Confirmed Influenza Cases
Fax to WECHU @ 226 894-3768

Facility Name: _____ Outbreak #: 2268 - _____ - _____

Please complete the following for line listed residents who were Lab confirmed cases of Influenza.

1. Resident Name: _____ Gender: M F DOB (YY/MM/DD) _____

Influenza Vaccine:	Lot #:	Date Administered:
--------------------	--------	--------------------

Hospitalization: Y N If Yes, please provide hospitalization details and underlying medical conditions:

2. Resident Name: _____ Gender: M F DOB (YY/MM/DD) _____

Influenza Vaccine:	Lot #:	Date Administered:
--------------------	--------	--------------------

Hospitalization: Y N If Yes, please provide hospitalization details and underlying medical conditions:

3. Resident Name: _____ Gender: M F DOB (YY/MM/DD) _____

Influenza Vaccine:	Lot #:	Date Administered:
--------------------	--------	--------------------

Hospitalization: Y N If Yes, please provide hospitalization details and underlying medical conditions:

4. Resident Name: _____ Gender: M F DOB (YY/MM/DD) _____

Influenza Vaccine:	Lot #:	Date Administered:
--------------------	--------	--------------------

Hospitalization: Y N If Yes, please provide hospitalization details and underlying medical conditions:

Completed By: _____
(Print Name)