

Foodborne Illness - First Response Form
Epidemiology Program EP/FD(yy/yy) _____ # _____

Initial report: Date _____ Time _____

Person reporting incident: Name _____ Age _____

Address _____

Telephone # (H) _____ (W) _____

Does incident involve illnesses of vomiting or diarrhea? Yes ___ No ___ How many people ill? _____

Establishment implicated: Name _____

Address or _____

Cross street _____

Suspect event or food item(s): _____

Date and times food *purchased*: _____ *eaten*: _____

Describe symptoms: _____

Date and time symptoms *began*: _____ (incubation period: _____)

List all food and beverages eaten: _____

Names of all who shared common meal, both sick and well:

1.) Name _____ Age _____ 2.) Name _____ Age _____

Address _____ Address _____

Phone # _____ Phone# _____

3.) Name _____ Age _____ 4.) Name _____ Age _____

Address _____ Address _____

Phone # _____ Phone# _____

Did illness require medical treatment? Yes ___ No ___ How many sought medical treatment? _____

Where did they receive treatment? _____

Hospitalized? Yes ___ No ___ Admission date _____ Room # _____

Additional comments: _____

Initial report taken by: _____ Investigator: _____