Appendix 6: Close Contact Daily Clinical Update Form

Contact Last Name: ________ Contact First Name: _______ Date of Birth: __________ (yy/mm/dd) Gender: ________

PHU representative: ________________________________

Follow-up Date/Time (YEAR/MM/DD and 24 Hour Clock)	Symptoms? (Y/N)	If yes, please specify (e.g., fever >38; cough, difficulty breathing, headache, fatigue, sore throat, chills, muscle pain, nasal congestion, nausea, vomiting, diarrhea, joint pain, decreased appetite)	Did contact seek medical attention for ARI symptoms? (Y/N)	If yes, please specify where contact went to seek attention (e.g., primary health care, home care, acute care, etc.)

Follow-up Date/Time (YEAR/MM/DD and 24 Hour Clock)	Symptoms? (Y/N)	If yes, please specify (e.g., fever >38; cough, difficulty breathing, headache, fatigue, sore throat, chills, muscle pain, nasal congestion, nausea, vomiting, diarrhea, joint pain, decreased appetite)	Did contact seek medical attention for ARI symptoms? (Y/N)	If yes, please specify where contact went to seek attention (e.g., primary health care, home care, acute care, etc.)