Facility:_____

Contact Person:_____

Influenza Line List

Date:___/___/____

	Name	Room #	Flu Vaccine Received Yes/No	Temp	Cough Yes/No	Sore Throat Yes/No	Influenza Testing			Treatment (Tamiflu, Amantadine, Antibiotics)	Cohorted Yes/No	Hospitalized				Outcome (Recovered, Transferred, Deceased)
							Rapid, Culture, Other	Test Date	Result			Yes/No	Hospital	Admit Date	Discharge Date	
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