# Suspected Food Borne Illness Report

Early Learning
psesd
excellence & equity in education
Puget Sound Educational Service District

Center/Site:_____ Date:_____

Staff name taking report:_____ Phone:_____

Child's name:_____ Parent's name:_____

Address:_____ City:_____ Zip:_____

Home phone: _____ Work phone: _____

## Questions for Parents

What foods were eaten by child in last 48 hours'? _____

Date of suspected meal exposure (month/day/year:_____ Time:_____am _____ pm

Onset of symptoms (month/day/year):_____ Time:_____am _____ pm

Did symptoms include:

Nausea_____ Aches _____ Chills_____
Vomiting _____ Diarrhea_____ Shortness of breath _____
Cramps _____ Bloody Diarrhea _____ Numbness or tingling _____
Fever_____ Headache _____ Other _____

Doctor/Hospital Name:_____ Phone ( ) _____
What, if any, treatment was given: _____
_____

Have other members of the household been ill with similar symptoms: ____Yes_____No
Samples available: Vomitus _____ Stool _____

## For staff to complete:

List all foods served to children in program on suspect day(s): _____

How many children / staff ate on suspect day(s)? _____ How many reported symptoms: _____

Are food samples available from site food service provider? _____

Name(s) of Staff/Volunteers who were involved in food handling on day(s) in question: _____

_____

Have above Staff/Volunteers experienced recent illness with similar symptoms? _____ Yes _____No

If yes, who: _____

**Please include a copy of the food temperature log for meals in question.**

**For ESD Staff:**

| | Agency | Person | Phone |
|---|---|---|---|
| Other Departments/Agencies Notified: | | | |

Additional Information Needed: _____

## Related Documents

Suspected Food Borne Illness Procedure