



Outbreak Reporting Module

The outbreak reporting module is intended for the following facilities to report outbreak information to Sacramento County Public Health as required by [Title 17](#) and [Assembly Bill 685](#):

- Businesses
- Childcares, Daycares, and Preschools
- Correctional Facilities
- Health Care Providers
- Homeless Shelters
- Schools

Please submit responses within 24 hours after starting the reporting session. Responses not submitted within 24 hours will not be recorded.





Point of Contact*

Name of reporter

First Last

Title/position of reporter

Title

Phone number (xxx-xxx-xxx)

555-555-5555

Email
(example@email.com)

email@company.com



Disease

Chickenpox (Varicella)

COVID-19

Flu (influenza)

Measles

Pertussis (Whooping Cough)

Rubella (German Measles)

Norovirus

Salmonella

Carbapenem-producing organism (CPO)

Methicillin-resistant Staphylococcus aureus (MRSA)

Unknown

Other



If disease = Unknown or Other



Disease type

Gastrointestinal (GI)

Rash

Respiratory

Other



SACRAMENTO COUNTY




**PUBLIC
HEALTH**

Promote • Prevent • Protect

* response required

Type of Facility*

Homeless Shelter 





Facility Name*

Facility Address

Street

City

Zip Code





Staff

Total number at facility

Number of cases

Resident(s)

Total number at facility

Number of cases



COVID case log part 1



Case Information (1-10)

	Name		Date of birth	Gender	Race/Ethnicity	Staff	Address (if staff)		
	Last name	First name	(mm/dd/yyyy)				Street	City	Zip
Case 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="v"/>	<input type="text" value="v"/>	<input type="text" value="v"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Case 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="v"/>	<input type="text" value="v"/>	<input type="text" value="v"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Case 3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="v"/>	<input type="text" value="v"/>	<input type="text" value="v"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Case 4	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="v"/>	<input type="text" value="v"/>	<input type="text" value="v"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Case 5	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="v"/>	<input type="text" value="v"/>	<input type="text" value="v"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Case 6	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="v"/>	<input type="text" value="v"/>	<input type="text" value="v"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Case 7	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="v"/>	<input type="text" value="v"/>	<input type="text" value="v"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Case 8	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="v"/>	<input type="text" value="v"/>	<input type="text" value="v"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Case 9	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="v"/>	<input type="text" value="v"/>	<input type="text" value="v"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Case 10	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="v"/>	<input type="text" value="v"/>	<input type="text" value="v"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

COVID case log part 3

Symptoms: Muscle aches	Symptoms: Nausea	Symptoms: Rigors	Symptoms: Runny nose	Symptoms: Shortness of breath	Symptoms: Sore throat	Symptoms: Subjective fever	Symptoms: Vomiting	If other symptoms, specify	Symptom resolution date (if applicable) (mm/dd/yyyy)	Isolation/quarantine end date (mm/dd/yyyy)	Specimen type	Specimen collection date (mm/dd/yyyy)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	

COVID case log part 4

Test type	Test result	Severity	Date of death (if applicable) (mm/dd/yyyy)	Vaccinated for COVID	Vaccine type (if applicable)	Date(s) of vaccination (if applicable)			
						Dose 1 (mm/dd/yyyy)	Dose 2 (mm/dd/yyyy)	Dose 3 (mm/dd/yyyy)	Dose 4 (mm/dd/yyyy)
▼	▼	▼		▼	▼				
▼	▼	▼		▼	▼				
▼	▼	▼		▼	▼				
▼	▼	▼		▼	▼				
▼	▼	▼		▼	▼				
▼	▼	▼		▼	▼				
▼	▼	▼		▼	▼				
▼	▼	▼		▼	▼				
▼	▼	▼		▼	▼				
▼	▼	▼		▼	▼				
▼	▼	▼		▼	▼				

Do you need to enter additional cases (11-20)?

Yes

No

(repeats for cases 11-20 and 21-30, if necessary)

Non-COVID case log part 1



Case Information (1-10)

	Name		Date of birth	Gender	Race/Ethnicity	Staff
	Last name	First name	(mm/dd/yyyy)			
Case 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="v"/>	<input type="text" value="v"/>	<input type="text" value="v"/>
Case 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="v"/>	<input type="text" value="v"/>	<input type="text" value="v"/>
Case 3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="v"/>	<input type="text" value="v"/>	<input type="text" value="v"/>
Case 4	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="v"/>	<input type="text" value="v"/>	<input type="text" value="v"/>
Case 5	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="v"/>	<input type="text" value="v"/>	<input type="text" value="v"/>
Case 6	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="v"/>	<input type="text" value="v"/>	<input type="text" value="v"/>
Case 7	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="v"/>	<input type="text" value="v"/>	<input type="text" value="v"/>
Case 8	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="v"/>	<input type="text" value="v"/>	<input type="text" value="v"/>
Case 9	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="v"/>	<input type="text" value="v"/>	<input type="text" value="v"/>
Case 10	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="v"/>	<input type="text" value="v"/>	<input type="text" value="v"/>

Non-COVID case log part 4

If other symptoms, specify	Symptom resolution date (if applicable) (mm/dd/yyyy)	Isolation/quarantine end date (mm/dd/yyyy)	Specimen collection date (mm/dd/yyyy)	Specimen type (i.e. blood, CSF, urine)	Test type (i.e. culture, PCR)	Test result (organism)	Severity	Date of death (if applicable) (mm/dd/yyyy)
							▼	
							▼	
							▼	
							▼	
							▼	
							▼	
							▼	
							▼	
							▼	
							▼	

Do you need to enter additional cases (11-20)?

Yes

No

(repeats for cases 11-20 and 21-30, if necessary)