Facility: **Date:** **Line List for Influenza-like Illness - RESIDENTS**

Identification				Resident Location		Onset	Signs and Symptoms											Illness Outcome				
Name	DOB	Age	Gender	Resident's Wing	Resident's Room #	Date of Onset	Fever	Chills	Cough	Sore throat	Headache	Malaise/fatigue	Muscle aches	Nausea	Vomiting	Diarrhea	Influenza vaccine	Antiviral medication	Seen a clinician	Visited ER	Died	Days Hospitalized	Duration of Illness in Hours
Last, First	MM/DD/YYYY	Years	(M/F)		RM #	MM/DD/YYYY																Days	Hours