



CHILD CARE FACILITY/SCHOOL COMMUNICABLE DISEASE REPORTING FORM

Please complete all applicable areas and fax to the **Infectious Disease Program: FAX: 613-735-3067**

PHONE: 613-735-8653 or 1-800-267-1097 (Office Hours) | 613-735-9926 (After Hours)

Please Note: Regular office hours are:
Monday-Friday
8:30-4:30 (Sept-June)
8:00-4:00 (July & Aug)

FOR HEALTH UNIT USE ONLY

iPHIS Client ID:

iPHIS Case ID:

STUDENT INFORMATION

Last Name:

First Name:

DOB (y/m/d):

HIN#:

Gender: Male Female

Address:

City:

Postal Code:

FAMILY PHYSICIAN:

Phone #:

Fax #:

COMMUNICABLE DISEASE

Disease:

Date of Onset (y/m/d):

PARENT/GUARDIAN INFORMATION

Last Name:

First Name:

Phone #:

DAY CARE/SCHOOL REPORTING

Name of Facility:

Address:

Phone #:

Name of Person Reporting:

Date (y/m/d):