

MENINGOCOCCAL DISEASE CONTACT ROSTER



Index Case Name: _____ VCMR# _____

Period of Infectivity from ___/___/___ to ___/___/___
(7 days prior to onset date of Index Case)

Date PHN Received Case Report: ___ / ___ / ___

Date of Initial PHN Call	Last/First Name	Age	Relationship	Prophylaxis	Tx. Date	Given by	Comments
/ /			<input type="checkbox"/> Household/Family <input type="checkbox"/> Work <input type="checkbox"/> Friend <input type="checkbox"/> Other <input type="checkbox"/> School	<input type="checkbox"/> Rifampin <input type="checkbox"/> Ceft <input type="checkbox"/> Cipro <input type="checkbox"/> Unknown	/ /	<input type="checkbox"/> Public Health Dept. <input type="checkbox"/> ER <input type="checkbox"/> PMD <input type="checkbox"/> Other	
/ /			<input type="checkbox"/> Household/Family <input type="checkbox"/> Work <input type="checkbox"/> Friend <input type="checkbox"/> Other <input type="checkbox"/> School	<input type="checkbox"/> Rifampin <input type="checkbox"/> Ceft <input type="checkbox"/> Cipro <input type="checkbox"/> Unknown	/ /	<input type="checkbox"/> Public Health Dept. <input type="checkbox"/> ER <input type="checkbox"/> PMD <input type="checkbox"/> Other	
/ /			<input type="checkbox"/> Household/Family <input type="checkbox"/> Work <input type="checkbox"/> Friend <input type="checkbox"/> Other <input type="checkbox"/> School	<input type="checkbox"/> Rifampin <input type="checkbox"/> Ceft <input type="checkbox"/> Cipro <input type="checkbox"/> Unknown	/ /	<input type="checkbox"/> Public Health Dept. <input type="checkbox"/> ER <input type="checkbox"/> PMD <input type="checkbox"/> Other	
/ /			<input type="checkbox"/> Household/Family <input type="checkbox"/> Work <input type="checkbox"/> Friend <input type="checkbox"/> Other <input type="checkbox"/> School	<input type="checkbox"/> Rifampin <input type="checkbox"/> Ceft <input type="checkbox"/> Cipro <input type="checkbox"/> Unknown	/ /	<input type="checkbox"/> Public Health Dept. <input type="checkbox"/> ER <input type="checkbox"/> PMD <input type="checkbox"/> Other	
/ /			<input type="checkbox"/> Household/Family <input type="checkbox"/> Work <input type="checkbox"/> Friend <input type="checkbox"/> Other <input type="checkbox"/> School	<input type="checkbox"/> Rifampin <input type="checkbox"/> Ceft <input type="checkbox"/> Cipro <input type="checkbox"/> Unknown	/ /	<input type="checkbox"/> Public Health Dept. <input type="checkbox"/> ER <input type="checkbox"/> PMD <input type="checkbox"/> Other	
/ /			<input type="checkbox"/> Household/Family <input type="checkbox"/> Work <input type="checkbox"/> Friend <input type="checkbox"/> Other <input type="checkbox"/> School	<input type="checkbox"/> Rifampin <input type="checkbox"/> Ceft <input type="checkbox"/> Cipro <input type="checkbox"/> Unknown	/ /	<input type="checkbox"/> Public Health Dept. <input type="checkbox"/> ER <input type="checkbox"/> PMD <input type="checkbox"/> Other	
/ /			<input type="checkbox"/> Household/Family <input type="checkbox"/> Work <input type="checkbox"/> Friend <input type="checkbox"/> Other <input type="checkbox"/> School	<input type="checkbox"/> Rifampin <input type="checkbox"/> Ceft <input type="checkbox"/> Cipro <input type="checkbox"/> Unknown	/ /	<input type="checkbox"/> Public Health Dept. <input type="checkbox"/> ER <input type="checkbox"/> PMD <input type="checkbox"/> Other	
/ /			<input type="checkbox"/> Household/Family <input type="checkbox"/> Work <input type="checkbox"/> Friend <input type="checkbox"/> Other <input type="checkbox"/> School	<input type="checkbox"/> Rifampin <input type="checkbox"/> Ceft <input type="checkbox"/> Cipro <input type="checkbox"/> Unknown	/ /	<input type="checkbox"/> Public Health Dept. <input type="checkbox"/> ER <input type="checkbox"/> PMD <input type="checkbox"/> Other	
/ /			<input type="checkbox"/> Household/Family <input type="checkbox"/> Work <input type="checkbox"/> Friend <input type="checkbox"/> Other <input type="checkbox"/> School	<input type="checkbox"/> Rifampin <input type="checkbox"/> Ceft <input type="checkbox"/> Cipro <input type="checkbox"/> Unknown	/ /	<input type="checkbox"/> Public Health Dept. <input type="checkbox"/> ER <input type="checkbox"/> PMD <input type="checkbox"/> Other	