

Clinical Data Report

Location Date of report (dd/mm/yy) / /.....
Reporter Tel

Patient information

Name-Surname Age year/month Sex ☐ male ☐ female
Parent's name (for children under 15)
School and level of student Immunization record

Clinical data

Date of onset Temp....., BP....., P....., Resp.....
Signs and symptoms (select signs and symptoms detected from the patient)

<input type="checkbox"/> Headache	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Skin rash
<input type="checkbox"/> Sore throat	<input type="checkbox"/> Sweating	<input type="checkbox"/> Purpura
<input type="checkbox"/> Stiff neck	<input type="checkbox"/> Loose stool	<input type="checkbox"/> Skin ulcer
<input type="checkbox"/> Neck swelling	<input type="checkbox"/> Bloody Stool	<input type="checkbox"/> Petechiae
<input type="checkbox"/> Confusion	<input type="checkbox"/> Watery stool	<input type="checkbox"/> Skin rash
<input type="checkbox"/> Nose Bleed	<input type="checkbox"/> Mucous stool	<input type="checkbox"/> Edema
<input type="checkbox"/> Numbness	<input type="checkbox"/> Chill Cramp	<input type="checkbox"/> Erythema
<input type="checkbox"/> Tingling	<input type="checkbox"/> Fever	<input type="checkbox"/> Conjunctivitis
<input type="checkbox"/> Seizures	<input type="checkbox"/> Cough	<input type="checkbox"/> Retro orbital pain
<input type="checkbox"/> Shock	<input type="checkbox"/> Chest discomfort	<input type="checkbox"/> Skin rash
<input type="checkbox"/> Stupor	<input type="checkbox"/> Palpitation	<input type="checkbox"/> Painful urination
<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Chest/arm pain	<input type="checkbox"/> Bloody urine
<input type="checkbox"/> Nausea	<input type="checkbox"/> Sweating	Other