Local Health Department: _____ Contact Person: _____ Tel. Number: _____ Page ___ of ___

## MEASLES CONTACT TRACING for _____ (insert name of Case)

| First Name and Last Name | DEMOGRAPHIC | | | | | EXPOSURE | | | | CLINICAL | | | | PUBLIC HEALTH | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **DOB** (mm/dd/yyyy) | **Age** (days/ months/ yrs) | **Address** (street, city, zip) | **County of Residence** | **Tel. Number** (home, work, cell) | **Date of FIRST** contact/ exposure to case (mm/dd/yy) | **Date of LAST** contact/ exposure to case (mm/dd/yy) | **Exposure setting** (home, school, work, hosp, daycare, etc.) | **Relation to case** (household member, caregiver, friend, co-worker, relative, etc.) | **Symptomatic?** (Yes/No). If yes, specify symptoms | **Symptom Onset Date**, if symptomatic (mm/dd/yy) | **Immune compromised** (Yes/No) | **Evidence of Measles Immunity** (Y/N). If yes, specify* | **Date contacted by LHD** (mm/dd/yy) | **Action/ Recommendation** |
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* If YES, choose reason below:

A. 2-dose measles vaccine on or after 1st birthday 28 days apart

B. lab evidence of immunity

C. lab confirmation of disease

D. born before 1957

May 2023