



## MENINGOCOCCAL DISEASE CONTACT ROSTER



Index Case Name: \_\_\_\_\_ Incident ID: \_\_\_\_\_

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"/> School <input type="checkbox"/> Other*	<input type="checkbox"/> Rifampin <input type="checkbox"/> Ceftriaxone <input type="checkbox"/> Azithromycin <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"/> School <input type="checkbox"/> Other*	<input type="checkbox"/> Rifampin <input type="checkbox"/> Ceftriaxone <input type="checkbox"/> Azithromycin <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"/> School <input type="checkbox"/> Other*	<input type="checkbox"/> Rifampin <input type="checkbox"/> Ceftriaxone <input type="checkbox"/> Azithromycin <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"/> School <input type="checkbox"/> Other*	<input type="checkbox"/> Rifampin <input type="checkbox"/> Ceftriaxone <input type="checkbox"/> Azithromycin <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"/> School <input type="checkbox"/> Other*	<input type="checkbox"/> Rifampin <input type="checkbox"/> Ceftriaxone <input type="checkbox"/> Azithromycin <input type="checkbox"/> Unknown		<input type="checkbox"/> Public Health Dept. <input type="checkbox"/> ER <input type="checkbox"/> PMD <input type="checkbox"/> Other*	
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			<input type="checkbox"/> Household/Family <input type="checkbox"/> Work <input type="checkbox"/> Friend <input type="checkbox"/> School <input type="checkbox"/> Other*	<input type="checkbox"/> Rifampin <input type="checkbox"/> Ceftriaxone <input type="checkbox"/> Azithromycin <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"/> School <input type="checkbox"/> Other*	<input type="checkbox"/> Rifampin <input type="checkbox"/> Ceftriaxone <input type="checkbox"/> Azithromycin <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"/> School <input type="checkbox"/> Other*	<input type="checkbox"/> Rifampin <input type="checkbox"/> Ceftriaxone <input type="checkbox"/> Azithromycin <input type="checkbox"/> Unknown		<input type="checkbox"/> Public Health Dept. <input type="checkbox"/> ER <input type="checkbox"/> PMD <input type="checkbox"/> Other*	

\*If Other, please specify in the comments.