Line List – Residents **Facility Name:_______________________________**

First and last name	DOB	Sex	Room No.	Ever had symptoms (Y/N)	Date of Onset	Duration of Illness	Fever (Record highest temp.)	Symptoms – see list ^	Ever Hospitalized (Y/N)	Hospital admission date	Death (Date)	Were ANY COVID tests POSITIVE? (Y/N)	Collection date for 1st Positive specimen	Date of most recent COVID test specimen collection	Most recent COVID result *	Flu testing (+ or -)	Notes/tests for other pathogens	Current status of cases **(optional)	Dates and Results of additional COVID tests (optional)	COVID vaccine dose 1 (date) or N/A	COVID vaccine dose 2 (date) or N/A

^Fever (F);Cough (C); Sore Throat (ST); Shortness of breath (B), Runny Nose (R); Nasal Congestion (N); Chest Congestion (CC); Muscle Aches (MA); Chills (Ch), Loss of Taste/Smell (L); Headache (H), Vomiting (V); Diarrhea (D)

*Positive (+); Negative (-); Pending (P)

**Not cleared (NC) Transmission-Based Precautions, Released from Transmission-Based Precautions (R), Unknown (U), N/A