TN Department of Health

Infant Botulism Case Report Form

Physician Contact: _____

Phone: _____

Antitoxin Released: ☐ Yes ☐ No ☐ Unknown

Antitoxin Administered: ☐ Yes ☐ No ☐ Unknown

If yes, **Date:** ____/____/____ **Time:** _____

Shipping / delivery details: _____

DEMOGRAPHICS

Last Name: _____ **First:** _____ **Middle:** _____ **DOB:** ____/____/____

If child <18: Parent's Last Name: _____ **First:** _____

Reported Age: _____ ☐ Days ☐ Months ☐ Years **Sex:** ☐ Male ☐ Female ☐ Unknown

Street Address: _____

City: _____ **County:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work:** _____ **Cell:** _____

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Unknown

Race: ☐ American Indian / Alaskan ☐ Asian ☐ Black / African American ☐ Hawaiian / Pacific Islander ☐ White ☐ Other: _____ ☐ Unknown

Daycare: _____ **Address:** _____

PRESENT ILLNESS

Onset Date: ____/____/____ **Attending or consulting physician:** _____ **Phone:** _____

Hospitalized: ☐ Yes ☐ No **Hospital:** _____ **Phone:** _____

Admission Date: ____/____/____ **Discharge Date:** ____/____/____ **Admitted to Intensive Care:** ☐ Yes ☐ No ☐ Unknown

Outcome: **Ventilator:** ☐ Yes ☐ No ☐ Unknown

Recovered: ☐ Yes ☐ No ☐ Unknown

Died: ☐ Yes ☐ No ☐ Unknown *if yes,* **Date of Death:** ____/____/____

SYMPTOMS

Vomiting	☐	**Excessive drooling**	☐	**Head drooping**	☐
Diarrhea	☐	**Change in voice / weak cry**	☐	**Facial drooping**	☐
Constipation	☐	**Drooping eyelids**	☐	**Other:** _____	
Floppy movements / weakness	☐	**Difficulty feeding / swallowing**	☐		
Shortness of breath / respiratory difficulty	☐	**Failure to thrive**	☐		

POSSIBLE SOURCES OF INFECTION DURING EXPOSURE PERIOD (WITHIN 30 DAYS OF ILLNESS ONSET)

Was infant ever breast fed? ☐ Yes ☐ No ☐ Unknown *if yes,* **for how many weeks?** _____

Was infant ever formula fed? ☐ Yes ☐ No ☐ Unknown *if yes,* **for how many weeks?** _____

Was infant taken on any walks / hikes? ☐ Yes ☐ No ☐ Unknown *if yes,* **where?** _____

Was infant exposed to any construction / agricultural sites? ☐ Yes ☐ No ☐ Unknown *if yes,* **where?** _____

Is the case a recent foreign arrival (e.g., immigrant, refugee, adoptee, visitor)? ☐ Yes ☐ No ☐ Unknown

Did the infant eat or taste any of the following:

	Never	Once / few times	Many times	Daily	Principal Brand
Cow's milk	☐	☐	☐	☐	_____
Fruit juice	☐	☐	☐	☐	_____
Syrup / corn syrup	☐	☐	☐	☐	_____
Honey	☐	☐	☐	☐	_____
Tea	☐	☐	☐	☐	_____
Cooked foods	☐	☐	☐	☐	_____
Raw fruits / vegetables	☐	☐	☐	☐	_____
Cooked vegetables	☐	☐	☐	☐	_____
Dried, cooked, smoked or traditionally prepared meat / fish	☐	☐	☐	☐	_____
Home canned foods	☐	☐	☐	☐	_____
Baby food (from a jar)	☐	☐	☐	☐	_____