

Diphtheria surveillance report: The close contacts

LEB-A36-|_|_|_|_|_|-|_|_|_|

#	Name	Date of birth	Gender	Relation	Immunization			Symptoms	Clinical swab			ATB Prophylaxy	Diphth. Toxoid
					Document	Nb doses	Year last dose		Done	Date	Result		
			<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Pos. <input type="checkbox"/> Neg.	<input type="checkbox"/> Yes, _ <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Pos. <input type="checkbox"/> Neg.	<input type="checkbox"/> Yes, _ <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Pos. <input type="checkbox"/> Neg.	<input type="checkbox"/> Yes, _ <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Pos. <input type="checkbox"/> Neg.	<input type="checkbox"/> Yes, _ <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Pos. <input type="checkbox"/> Neg.	<input type="checkbox"/> Yes, _ <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Pos. <input type="checkbox"/> Neg.	<input type="checkbox"/> Yes, _ <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Pos. <input type="checkbox"/> Neg.	<input type="checkbox"/> Yes, _ <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Pos. <input type="checkbox"/> Neg.	<input type="checkbox"/> Yes, _ <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Pos. <input type="checkbox"/> Neg.	<input type="checkbox"/> Yes, _ <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Pos. <input type="checkbox"/> Neg.	<input type="checkbox"/> Yes, _ <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Diphtheria. Agent: toxins produced by Corynebacterium diphtheriae. Reservoir: Humans. Transmission: contact with a patient or a carrier; rarely indirect through contact with articles soiled with discharges from lesions of infected patient; raw milk. Incubation: 2-5 days. Communicability: variable, until bacilli disappeared from discharges and lesions, usually 2 weeks, seldom 4 weeks.

ATB: 1 Erythromycin; 2 Penicillin; 3 Amoxicillin/Ampicillin/Augmentin/Ceclor/Cefixime; 4 Clarithromycin/azithromycin; 5 Cotrimoxazole; 6 Tetracyclin; 7 Other