Check one:

Park:_____

Gastrointestinal Illness Incident Report

National Park Service
Public Health Program

Personal Information

First Name_____ Last Name_____

Date of Birth___/___/___ (mm/dd/yy) Sex: ☐Female ☐Male

Parent's Name (if child<18): First Name_____ Last Name _____

Address _____ City_____

State/Province_____ County_____ Country_____ Postal Code_____

Telephone_____ Alternate Telephone_____

Check One: ☐Park Visitor ☐NPS Employee ☐Concessionaire Employee ☐Park Resident

Medical Treatment

Has the person experiencing gastrointestinal symptoms sought medical treatment? ☐Yes ☐No

If Yes: Clinic name_____ Date of clinic visit ___/___/___ (mm/dd/yy)

Diagnosis _____

Does the person attribute the illness to a non-infectious cause (e.g., chronic medical condition (irritable bowel syndrome, inflammatory bowel disease, stomach ulcers, etc.), alcohol consumption, pregnancy, medication, menstruation, etc.)?

☐Yes ☐No ☐Unknown

Did the person take any medications for this illness (e.g., antibiotics, anti-diarrheal medications, etc.)? ☐Yes ☐No

Symptoms Experienced During this Illness

Nausea	☐Yes	☐No	Sweats/Chills	☐Yes	☐No	Date of illness onset: ____/____/____ (mm/dd/yy)
Vomiting	☐Yes	☐No	Other	☐Yes	☐No	Time of onset: _____ ☐AM ☐PM
Diarrhea	☐Yes	☐No	If yes to "Other", describe:			Location of onset:
Blood in stool	☐Yes	☐No	_____			_____
Stomach cramps	☐Yes	☐No	_____			Date of recovery: ____/____/____ (mm/dd/yy)
Fever	☐Yes	☐No	_____			
Highest Temp _____ °F			_____			

Trip Specific Information (River, Backcountry, Bus, Concessionaire-led)

Start Date: ____/____/____ (mm/dd/yy)	End Date: ____/____/____ (mm/dd/yy)	Comments:
Starting location: _____	Ending location: _____	

Form Completed by (person's name): First Name _____ Last Name_____

Please specify reporting agency/company:

☐NPS ☐ Concessionaire (company name) _____