TYPHOID CARRIER RECORD

MISSOURI DEPARTMENT OF HEALTH

Name _____ (LAST / FIRST / MIDDLE)

Other Names _____ (MAIDEN, NICKNAME, ETC.)

Address _____

Occupation _____

Physician _____

Health Unit having Jurisdiction _____

History of Typhoid _____ Date _____

Date _____

Birth Date _____ Sex _____ Race _____

Date classified as carrier _____

Date carrier agreement signed _____

How discovered:

- ☐ Release specimens following typhoid
- ☐ Investigation of source of typhoid
- ☐ Transferred in from _____
- ☐ Other _____

Phage Type _____

Agglutinations _____

Laboratory examinations confirming carrier state:

DATE	CULTURE SPECIMENS			NAME AND ADDRESS OF LABORATORY
	FECES	URINE	OTHER (SPECIFY)	

Remarks: _____

DISPOSITION

Released _____ (DATE) Died _____ (DATE) Moved from _____

To _____ (DATE)

Laboratory examinations for release as required by regulations:

DATE	CULTURE SPECIMENS			NAME AND ADDRESS OF LABORATORY
	FECES	URINE	OTHER (SPECIFY)	

FOLLOW-UP

DATE	REMARKS (NEW ADDRESS, OCCUPATION, ILLNESS, TYPHOID CASES CREDITED TO CARRIER SINCE LAST REPORT, ADHERENCE TO AGREEMENT, ETC.)	DATE FAMILY CONTACTS LAST IMMUNIZED	DATE NEXT VISIT PLANNED