



Varicella Report Form

Demographic Information			
Name _____			
Address _____			
City _____	County _____	Zip _____	
Phone _____	Date of Birth or Age _____		
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian/PI <input type="checkbox"/> Am Indian <input type="checkbox"/> Other	Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
Clinical Information			
Rash Onset Date: ____/____/____ OR 1 st date child absent: ____/____/____ (due to chickenpox)	Received Varicella Vaccine: (check appropriate box) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, date(s) of vaccination: Varicella (VZV) dose 1: ____/____/____ Varicella (VZV) dose 2: ____/____/____		
Severity of Varicella: (check appropriate box) <input type="checkbox"/> < 50 lesions (mild) <input type="checkbox"/> 50 – 500 lesions (average) <input type="checkbox"/> > 500 lesions (severe)			
Hospitalized: (check appropriate box) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Outcome: (check appropriate box) <input type="checkbox"/> Alive <input type="checkbox"/> Dead <input type="checkbox"/> Unknown		
Diagnosed by: (check appropriate box) <input type="checkbox"/> Physician/nurse <input type="checkbox"/> School <input type="checkbox"/> Parent <input type="checkbox"/> Self <input type="checkbox"/> Other _____			
Reported date: ____/____/____			
Report Source: Name: _____ Agency/Site: _____			
Check appropriate box: <input type="checkbox"/> School <input type="checkbox"/> Pre-school/Childcare <input type="checkbox"/> Physician <input type="checkbox"/> Lab			
Phone number (should further information be needed): _____			
Reporting Information			
<p>Please fax reports to: 330-752-7157</p>			
Questions? Summit County Public Health Communicable Disease Unit 330-375-2662			