

# Varicella Report Form

ASHTABULA COUNTY HEALTH DEPARTMENT

## Demographic Information

Child's Name _____		Parent's Name _____	
Address _____			
City _____	County _____	Zip _____	
Phone _____		Date of Birth / 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: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Onset Date: ____/____/____  <b>Location of rash</b> _____ Fever: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown 1 <sup>st</sup> date child absent: ____/____/____ <small>(due to chickenpox)</small>	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)  
 School  Pre-school/Childcare  Physician  Lab

Phone number (should further information be needed): \_\_\_\_\_

## Reporting Information

**Please fax reports at the end of each work week to:**  
**440 – 576 – 0001**

QUESTIONS? PLEASE CONTACT NURSING DIVISION: 440-576-3023