

# Varicella Report Form

Health Department

## Demographic Information

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

County \_\_\_\_\_

Zip \_\_\_\_\_

Phone \_\_\_\_\_

Date of Birth or Age \_\_\_\_\_

Sex:  Male  
 Female

Race:  White  Black  Asian/PI  
 Am Indian  Other

Ethnicity:  Hispanic  
 Non-Hispanic

Parent/Guardian Name: \_\_\_\_\_

## Clinical Information

Rash Onset Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**OR**

1<sup>st</sup> date child absent: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(due to chickenpox)

Received Varicella Vaccine: (check appropriate box)  
 Yes  No  Unknown

If yes, date(s) of vaccination:

Varicella (VZV) dose 1: \_\_\_\_/\_\_\_\_/\_\_\_\_

Varicella (VZV) dose 2: \_\_\_\_/\_\_\_\_/\_\_\_\_

Severity of Varicella: (check appropriate box)

< 50 lesions  
(mild)

50 – 500 lesions  
(average)

> 500 lesions  
(severe)

Hospitalized: (check appropriate box)

Yes  No  Unknown

Outcome: (check appropriate box)

Alive  Dead  Unknown

Diagnosed by: (check appropriate box)

Physician/nurse  School  Parent  Self  Other \_\_\_\_\_

Reported date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Reported by:

Name: \_\_\_\_\_

Facility: \_\_\_\_\_ Phone number: \_\_\_\_\_

(check appropriate box)

School  Pre-school/Childcare  Physician  Lab

## Reporting Information

**Alliance City Health Department**

(330) 821-7373  
(330) 821-9517 Fax

**Massillon City Health Department**

(330) 830-1710  
(330) 830-2852 Fax

**Canton City Health Department**

(330) 489-3322  
(330) 430-7857 Fax

**Stark County Health Department**

(330) 493-9928  
(330) 493-9932 Fax