

Varicella Report Form

Ashtabula County Health Department – Communicable Disease

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

Clinical Information

Rash Onset Date: ____/____/____

OR

1st 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: ____/____/____

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? Call Ashtabula County Health Department (440) 576-3023