Varicella Report Form

Ohio Department of Health

Case Name:
Last _____ First _____ Middle_____

Parent Name (for minors) _____

Address

City	Zip	County
Phone	Date of Birth	

Sex: □ Male □ Female	Race: □ White □ Black □ Asian/PI □ Am. Indian □ Other _____	Ethnicity: □ Hispanic □ Non-Hispanic

Clinical Information

Onset date of rash: ____/____/____
Location of rash_____
Fever: □ Yes □ No □ Unknown
Onset date of fever: ____/____/____
1st date child absent from school:
____/____/____ (due to chickenpox)

Received Varicella Vaccine:
□ Yes □ No □ Unknown
If yes, date(s) of vaccination:
Varicella vaccine dose 1:____/____/____

Varicella vaccine dose 2:____/____/____

Severity of Varicella: □ < 50 lesions (Severity I) □ 50 – 500 lesions (Severity II) □ > 500 lesions (Severity III)

Type of lesions: (check all that apply)
□ flat □raised □ fluid filled □ crops/waves □ crusting □ scabbing □ itching

Complications:	Hospitalized: □ Yes □ No	Outcome: □ Recovered □ Died ___/___/___

Diagnosed by: □ Physician/Nurse □ School □ Parent □ Self □ Other_____

Report Source: □ School □ Pre-school/Childcare □ Physician □ Lab

Name:_____ Agency/Site_____

Signature: _____ Phone: _____

Please forward reports to Ashland County-City Health Department by the end of the work week
Fax: 419-282-4271
Questions? Contact Linda McCarty RN at 419-282-4356 or Shirley Bixby at 419-282-4232

Revised 9/2011