Varicella Report Form

Cuyahoga County Public Health Collaborative

Demographic Information

Child's Name | Parent's Name

Address

City | County | Zip

Phone | Date of Birth / Age

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

Clinical Information

Rash: □ Yes □ No □ Unknown
Onset Date: ____/____/____

Location of rash_____
Fever: □ Yes □ No □ Unknown
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:

216.676.1316

Questions? Please contact Epidemiology and Surveillance: 216.201.2080

Form is available for download at: http://www.ccbh.net/pdf/varicella_form.pdf