Varicella Report Form

Ohio Department of Health

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 (Severity I)　□ 50 – 500 lesions (Severity II)　□ > 500 lesions (Severity III)

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 forward reports to your local health jurisdiction by the end of the work week.

Questions? Please contact your local health department.