

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 fax reports at the end of each work week to:

614-719-8890

Questions? Please contact Communicable Disease Reporting System (CDRS): 614-719-8888