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 or mail this completed form to Judith Beiting, BSN, RN at the end of the work week

FAX: 513/946-7930
Mail: Judith Beiting
Hamilton County General Health District
250 William Howard Taft Rd. 2nd Floor
Cincinnati, OH 45219