



## VARICELLA (chickenpox) Reporting Form

Please use this form to report cases of varicella. You can fax a copy of this document to Collin County Health Care Services 972-548-4436 Please complete as many of the questions as possible. A report can still be submitted if all questions cannot be answered.

Onset Date ____/____/____ Last day of school attended ____/____/____	History of Disease?                      Yes              No              Date of Disease ____/____/____ Vaccinated against Varicella?              Yes              No              Number of Doses Received?    1              2 Date(s) Varicella Vaccine Administered:    (1) ____/____/____              (2) ____/____/____			
LAST NAME	FIRST	DOB	AGE	SEX
ADDRESS		CITY		ZIP CODE
PHONE		RACE		HISPANIC? Yes                      No
Is this patient a contact to another known Varicella case? Name of contact:  Phone:		Was the patient hospitalized? Yes                      No		Did the patient have a fever? Yes                      No Date:
Was lab testing done for Varicella?    Yes              No Lab test: DFA    PCR    IgM    IgG    Other Date: _____              Result:		Number of lesions in total: <i>(circle number of lesions)</i> <50              50-249  250-499              500+		Did the patient attend daycare/after school care? Yes                      No Name of Facility:
Ordering Physician:				

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ADDRESS		CITY		ZIP CODE
PHONE		RACE		HISPANIC? Yes                      No
Is this patient a contact to another known Varicella case? Name of contact:  Phone:		Was the patient hospitalized? Yes                      No		Did the patient have a fever? Yes                      No Date:
Was lab testing done for Varicella?    Yes              No Lab test: DFA    PCR    IgM    IgG    Other Date: _____              Result:		Number of lesions in total: <i>(circle number of lesions)</i> <50              50-249  250-499              500+		Did the patient attend daycare/after school care? Yes                      No Name of Facility:
Ordering Physician:				

Name of Person Reporting: \_\_\_\_\_ PHONE: \_\_\_\_\_

Agency/Organization Name: \_\_\_\_\_

Address: \_\_\_\_\_

CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_ COUNTY: \_\_\_\_\_

DATE REPORTED: \_\_\_\_\_