ERIE COUNTY DEPARTMENT OF HEALTH (ECDH)

VARICELLA REPORTING FORM (Chickenpox is reportable disease please report ASAP to the ECDH)

First Name_____Middle Name_____Last Name_____Date of Birth_____

Address_____Phone number_____ Parent or Guardian_____

Race_____Hispanic___Non-Hispanic___School/Place of employment_____Grade_____

Physician Name_____Phone number_____

Physician's Address_____City/State/Zip Code _____

Date of Onset_____Date of Diagnosis_____Who diagnosed current case?_____Lab confirmed?_____

Were the following tests ordered? **Any treatment ordered? (please check Y/N)**

TEST (please check Y/N)	Yes	No		Acyclovir	Yes	No
IgM antibody to VZG				Valacyclovir		
IgG antibody to VZG				Famciclovir		
VZV antigen detection				Other antiviral		
VZV nucleic acid detection (PCR, probe, LCR, etc				VZIG		
Culture/ID of VZG				Other -Please list.		

RASH & DISEASE SEVERITY INFORMATION

Rash onset date_____Number of days with rash at time of reporting_____ Total days of rash_____

Was the rash….	Yes	No		**Severity of rash** (***check box to right***)	√	Fever? _____
Macular/papular (red,raised bumps)				<50 lesions (can be counted in 30 sec. or less)		Highest Temp_____ Number of days with fever____
Vesicular (blisters)				50-249 lesions(clear area at least as big as child's hand can be placed betw lesions without touching a lesion)		Pregnant?_____EDC_____
Was rash itchy?				250-500 lesions (clear areas were not large enough to fit child's hand without touching lesions)		Person ill enough to be in bed? __ If so, how many days?_____
Did lesions scab?				>500 lesions (many lesions and in some areas you could not see normal skin between areas were lesions were found).		How many days of school/work did person miss? _____
Generalized?				***Any complications?*** _____If yes please list below:	=	Was person hospitalized?____
Localized?						
Unknown?						

MEDICAL HISTORY_____

Did person receive varicella vaccine? Yes____ No___ How many doses?____

Dose 1: Administration date:_____ Lot number_____ Dose 2: Administration date:_____Lot number_____

If person did not receive proper number of varicella vaccine what was/were the reason(s***)? Please*** **check** ***those that apply***.

MD diagnosis of previous disease___	Parental refusal _____	Religious exemption__	Other _____
Medical contraindication_____	Lab confirmation of previous disease __	Underage ___	

Prior history of chicken pox infection?___If so, was it doctor diagnosed?___If yes, by whom?_____

Any evidence of immunity to chickenpox?_____If yes, please list_____

Are there preexisting medical conditions? If so please list_____

Any medications taken during the 30 days before the chickenpox rash?___If so, please list name of medication(s) and reason for medication_____

Is transmission setting known?____If so, name and location of exposure_____

Was exposure to chickenpox? ___Was exposure to shingles?____Unknown exposure_____ Date of exposure_____

List any activities outside of home? (ie school, work, church, sports, buses) _____

Reported by_____Agency/School/MD_____Phone:_____ Date:_____

ATTENTION: Call or FAX to Erie County Department of Health, 606 W 2nd Street, Erie, PA 16507

Phone: (814)451-6700 Fax (814)451-6767

For ECDH use only: Call taken by_____ Date:_____ g:immi/varicella 3/12