

OTTAWA COUNTY HEALTH DEPARTMENT

Chickenpox (Varicella) Reporting Form

Please Fax Completed Form within 7 Days of Illness to Health Department at (616)393-5659

Date Illness Reported: ____/____/____

Diagnosed By: Doctor Parent Other: _____

Patient Name: _____

Parent or Guardian (required if under 18): _____

Address: _____ City: _____ Zip: _____

Phone: _____ Alternate Phone: _____

Sex: Male Female Age: _____ Date of Birth: _____

Race:

- Caucasian Hawaiian/Pacific Islander
 African American American Indian/Alaska Native
 Asian Other: _____
 Unknown

Ethnicity:

- Hispanic/Latino
 Not Hispanic/Latino
 Unknown

Varicella vaccination history

Has patient received varicella vaccine? Yes No Waiver Unknown

If yes: Dose #1: ____/____/____ (date)

Dose #2: ____/____/____ (date)

Severity of illness (as reflected by approximate number of lesions):

- Fewer than 50 (easily counted in 30 seconds)
 50-249 (patients hand can be placed on body without touching a lesion)
 250-499 (patients hand cannot be placed on body without touching one or more lesions)
 500 or more (cannot observe normal skin)

Name of person submitting this report: _____

Name of facility, office, or school: _____

Phone: _____ Fax: _____

Individual chickenpox (varicella) cases are required by law to be reported by physicians and schools in Michigan, effective Sept. 1, 2005

This reporting is expressly allowed under HIPAA Communicable Disease Rules: R325, 171, 172, 173

