

VARICELLA (Chickenpox) Reporting Form
Kansas Department of Health and Environment

Patient Information	Today's Date: ___ / ___ / ___ Is this case outbreak-related? (circle one) Y N Unknown
	Patient's Name: _____ <div style="display: flex; justify-content: space-around; width: 100%;"> Last First Middle </div>
	Day Phone: _____ Evening Phone: _____
	Residential Address: _____
	City: _____ Zip: _____ County: _____
	Ethnicity: (circle one) Hispanic or Latino Not Hispanic or Latino Unknown
	Race: (circle all that apply) American Indian/Alaska Native Asian Black/African American Native Hawaiian/Other Pacific Islander White Unknown
Sex: M F Date of Birth: ___ / ___ / _____ Age if DOB unknown: _____	
Clinical Information	Date of Rash Onset: ___ / ___ / ___ OR 1st date child absent due to chickenpox: ___ / ___ / ___
	Severity of Varicella: <input type="checkbox"/> Mild (<50 lesions) <input type="checkbox"/> Moderate (50-500 lesions) <input type="checkbox"/> Severe (>500 lesions)
	Hospitalized? (circle one) Y N Unknown Died? (circle one) Y N Unknown
	Diagnosed by: (circle one) Parent Physician/Nurse School Self Other _____
	Received previous varicella vaccine? (circle one) Y N Unknown If yes, dates: Varicella (VZV) dose 1 ___ / ___ / ___ Varicella (VZV) dose 2 ___ / ___ / ___
Laboratory	Specimen Collection Date: ___ / ___ / _____ Specimen Source: _____
	Type of Test Performed: _____ Results of Test: _____
	Name of Laboratory: _____ Laboratory Results Attached? Y N

Name of person reporting: _____ **Phone:** _____

Agency/Organization Name: _____

Type: (circle one) School Pre-school/Childcare Physician Health Department Laboratory

Comments: _____

Mail or Fax reports to your local health department or to:
 BEDP – Disease Surveillance, 1000 SW Jackson, Suite 210, Topeka, KS 66612-1274
FAX Toll-free to: 1-877-427-7318