

Kansas Varicella (Chickenpox) Reporting Form



Today's Date: ____ / ____ / ____

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

Varicella diagnosed by (circle one): Parent Physician/Nurse School Self Other _____

Date diagnosed: ____ / ____ / ____

Patient's Last Name: _____ **First Name:** _____ **Middle Name:** _____

Phone: _____ **Address:** _____

City: _____ **Zip:** _____ **County:** _____

Date of Birth: ____ / ____ / ____

- Race:** White Black Asian Amer Indian/Alaska Native Native Hawaiian/Pacific Islander
- Ethnicity:** Hispanic Non-Hispanic
- Sex:** Male Female
- Pregnant:** Yes No Unknown

Date of Rash Onset: ____ / ____ / ____

Total # of lesions:	< 50	50-249	250-500	> 500
Rash location:	Generalized	Focal	Unknown	
Mostly macular/papular?	Yes	No	Unknown	
Mostly vesicular?	Yes	No	Unknown	
Hemorrhagic?	Yes	No	Unknown	
Itchy?	Yes	No	Unknown	
Scabs?	Yes	No	Unknown	
Crops/waves?	Yes	No	Unknown	
Fever?	Yes	No	Unknown	
Immunocompromised?	Yes	No	Unknown	
Hospitalized?	Yes	No	Unknown	
Died?	Yes	No	Unknown	

Has previously received varicella vaccine? Yes No Unknown

Vaccine #1 date: ____ / ____ / ____ Vaccine #2 date: ____ / ____ / ____
 Vaccine #1 Type: _____ Vaccine #2 Type: _____
 Vaccine #1 Manufacturer: _____ Vaccine #2 Manufacturer: _____
 Vaccine #1 Lot #: _____ Vaccine #2 Lot #: _____

Attends/teaches school or daycare? Yes No Unknown

Facility Name: _____ Facility City: _____
 Grade/Room: _____
 Teacher: _____

Notify your local health department **immediately via telephone**,
 or contact KDHE's Bureau of Epidemiology and Public Health Informatics
 Fax: 877-427-7318 Epidemiology Hotline: 877-427-7317