KANSAS VARICELLA (CHICKENPOX) REPORTING FORM

Fax this form to UG PHD: 913-573-6744 or KDHE: 877-427-7318
Please include laboratory results, if available
To report urgent diseases, call the KDHE Epidemiology Hotline: 877-427-7317
This form is available at: www.kdheks.gov/epi/disease_reporting.html

Today's date: _____

PATIENT INFORMATION

Name: _____
Last *First* *Middle*

Mobile phone: _____ **Home phone:** _____

Residential address: _____

City: _____ **State:** _____ **Zip:** _____

Date of Birth (*if unknown, provide age*): _____

Race: ☐ White ☐ Black ☐ Asian ☐ American Indian / Alaska Native ☐ Native Hawaiian / Pacific Islander

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Sex: ☐ Male ☐ Female → **Pregnant?** ☐ Yes ☐ No ☐ Unknown

Associated with high-risk setting or institution? ☐ Daycare ☐ Nursing Home ☐ Health Care ☐ Correctional ☐ Food Handler ☐ Shelter ☐ School ☐ Other

Name and city of high-risk setting or institution: _____ **Grade/Room:** _____

DISEASE OR CONDITION INFORMATION

Has the patient/guardian been notified of varicella diagnosis? ☐ Yes ☐ No

Hospitalized? ☐ Yes → **Hospital:** _____ ☐ No ☐ Unknown

Died? ☐ Yes ☐ No

Has any laboratory testing been performed? ☐ Yes (enter below) ☐ No

Laboratory name: _____ **Specimen collection date:** _____

Test(s) performed: _____ **Test result(s):** _____

FACILITY AND PHYSICIAN INFORMATION

Facility name: _____ **Facility city:** _____

Physician name: _____ **Phone #:** _____

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

PLEASE CONTINUE TO PAGE TWO FOR SUPPLEMENTAL INFORMATION FOR REPORTING VARICELLA

(Revised 05/2018)

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SUPPLEMENTAL VARICELLA INFORMATION – CLINICAL SYMPTOMS

Rash onset date: _____ **Number of lesions:** ☐ <50 ☐ 50-249 ☐ 250-500 ☐ >500

Rash location: ☐ Generalized ☐ Focal ☐ Unknown

Description and characteristic of rash (select all that apply):

☐ Mostly macular/papular ☐ Mostly vesicular ☐ Hemorrhagic ☐ Pruritic (Itchy)

☐ Resolved (crusted) ☐ Crops/waves ☐ Other: _____

Patient febrile: ☐ Yes (Highest temp. _____ °F/C) ☐ No ☐ Unknown

Patient immunocompromised: ☐ Yes (Describe: _____) ☐ No ☐ Unknown

SUPPLEMENTAL VARICELLA INFORMATION – VACCINATION STATUS

Has patient previously received any varicella-containing vaccine? ☐ Yes (enter below) ☐ No ☐ Unknown

Vaccine One:
Date received: _____ **Type:** _____

Manufacturer: _____ **Lot Number:** _____

Vaccine Two:
Date received: _____ **Type:** _____

Manufacturer: _____ **Lot Number:** _____

If unimmunized (or under-immunized), please select reason(s) below:

☐ Medical contraindication ☐ Religious exemption ☐ Parental objection ☐ Alternative immunization schedule

☐ Philosophical objection ☐ Under age for vaccination (younger than 2 months) ☐ Unknown/other