



State of Connecticut

Department of Public Health

Varicella Case Report Form

Please make and use copies of this form.

Report Status

Date reported: ____ / ____ / ____ Reported by: _____ Phone #: _____

Reporting Site/Clinic: _____ Town/City: _____

Site Type reporting:

School Daycare Physician Health Dept. Other: _____

Demographic Information

Patient Name: _____ Date of Birth: ____ / ____ / ____ mm dd yyyy Age: _____

Address: _____ City: _____ Zip Code: _____ Home Phone: _____

Race: American Indian/Alaska Native Asian Black/African American Native Hawaiian/Other Pacific Islander White
 Unknown Other: _____

Ethnicity: Hispanic or Latino origin Not of Hispanic or Latino origin Unknown **Sex:** Male Female Unknown/Un-specified

Parent/Guardian Name (optional): _____ Parent/Guardian Work Phone (optional): _____

Case Attends: School Daycare Work College Other: _____

Name of Institution: _____ City: _____

Clinical Data

Rash Onset: ____ / ____ / ____
mm dd yyyy

Number of Lesions:

Less than Average (<50) Average (50-250) Greater than Average (>250)

Hospitalized? Yes No If yes, Hospital Name: _____ Days Hospitalized: _____

Diagnosed by:

Parent/Guardian Physician/Nurse School Self Other: _____

Lab Confirmed:

Yes No Unknown Test type: DFA IgM IgG PCR Other: _____ Result: _____

Previous History:

Chickenpox?: Yes No Unknown Age: _____

Vaccination?: Yes No Unknown

If yes, Date Administered: VZV Dose 1: ____ / ____ / ____ VZV Dose 2: ____ / ____ / ____

History of MMR:

Date Administered: MMR Dose 1: ____ / ____ / ____ MMR Dose 2: ____ / ____ / ____