

**CHICKENPOX REPORT FORM**  
**Colorado Department of Public Health and Environment**

<b>Name:</b> (last, first) _____	<b>Date of Birth (or age if birthdate is unavailable):</b> _____	<b>Home phone #:</b> _____	<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female
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**Race:** (check all that apply)  Amer. Ind./Alask.Nat.  Asian  Black  Other \_\_\_\_\_  
 Pacif./Hawaiian  White  Unknown

**Ethnicity:** (check appropriate box)  Hispanic  Non-Hispanic  Unknown

<b>County:</b> _____	<b>City:</b> _____	<b>Zip code:</b> _____	<b>Report date:</b> _____
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**Name of person filling out form:** \_\_\_\_\_

**Phone number for site or person completing form:** \_\_\_\_\_

**Report Site (Name of clinic/school/childcare center):** \_\_\_\_\_

Site is:  Employer  Health Department  Laboratory  Preschool / Childcare  Physician  
 School (If school, what is the grade level of the person with chickenpox? \_\_\_\_\_)  
 Other (specify) \_\_\_\_\_

<b>Rash Onset date:</b> ____/____/____ mm dd yyyy	<b>OR</b>	<b>Received Varicella Vaccine:</b> (check appropriate box) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>1<sup>st</sup> date child absent:</b> ____/____/____ (due to chickenpox) mm dd yyyy		<b>If yes date(s) of vaccination:</b> (mm/dd/yyyy) Varicella (VZV) dose 1 ____/____/____ Varicella (VZV) dose 2 ____/____/____

**Severity of Varicella:** (check the appropriate box)  
 < 50 lesions (mild)  50 – 500 lesions (average)  > 500 lesions (severe)  Unknown

<b>Hospitalized:</b> (check appropriate box) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>Outcome:</b> (check appropriate box) <input type="checkbox"/> Alive <input type="checkbox"/> Dead <input type="checkbox"/> Unknown
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**Diagnosed by:** (check appropriate box)  Parent  Physician/Nurse  School  Self  Unknown  
 Other (specify) \_\_\_\_\_

**If this person attends school or childcare, did anyone else at the school or childcare facility have chickenpox in the past 3 weeks?**  Yes  No  Unknown

**If yes, what is the name of the school or facility (if different than the reporting agency/site listed above)?**  
 \_\_\_\_\_

**Lab Testing:** (if known) Collection Date: \_\_\_\_\_ Result: \_\_\_\_\_ Specimen: \_\_\_\_\_

Reporting Lab: \_\_\_\_\_ Test type: \_\_\_\_\_

**Fax report to:** (303) 782-0338    **Questions call:** Denise Woods-Stout (303-692-2672) or Meghan Barnes (303-692-2671)  
**Mail report to:** Communicable Disease Program, A-3  
 Colorado Department of Public Health & Environment  
 4300 Cherry Creek Drive South  
 Denver, CO 80246-1530

For Additional Varicella Report Forms and Information: [www.cdph.state.co.us/dc/epidemiology/varicella](http://www.cdph.state.co.us/dc/epidemiology/varicella)