

Please Call the Health Department Immediately at 269-926-7121 and
Fax Completed Form within 24 hours of report to the Public Health Department at 269-927-5680

Date Illness Reported to Facility: _____

Diagnosed by: Physician Name: _____
 Parent
 Other: _____

Child's Name:	Parent or Guardian (required if under 18):	
Address:	City:	Zip:
Phone:	Alternate Phone:	
Date of Birth:	Age:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Teacher:	Classroom/Grade:	
Race:	Ethnicity:	
<input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unknown	

Varicella Vaccine History

Has the child received varicella vaccine?

- Yes
 No
 Waiver
 Unknown

If yes: Dose # 1: _____
 Dose # 2: _____

Severity of illness

(as reflected by approximate number of lesions)

- Fewer than 50 (easily counted in 30 seconds)
 50 – 249 (patients hand can be placed on body without touching a lesion)
 250 – 499 (patients hand cannot be placed on body without touching one or more lesions)
 500 + (cannot observe normal skin)

Name of Person Submitted by: _____
 Name of Facility: _____
 Phone: _____
 Fax: _____
 E-Mail: _____
 Date Submitted: _____