CITY OF SAN ANTONIO
METROPOLITAN HEALTH DISTRICT

VARICELLA (Chickenpox) Reporting Form

Please use this form to report cases of varicella. You can fax a copy of this document to the San Antonio Metropolitan Health District at (210) 207-8807. Please complete as many of the questions as possible. A report can still be submitted if all questions cannot be answered. Please send associated vaccination history and physician notes.

Onset Date ____/____/____ **Last day of school attended** ____/____/____	**History of Disease**? Yes No **Date of Disease**____/____/____ **Vaccinated against Varicella?** Yes No **Number of Doses Received?** 1 2 **Date(s) Varicella Vaccine Administered:** (1)____/____/____(2)____/____/____				
LAST NAME	**FIRST**	**DOB**	**AGE**	**SEX**	
ADDRESS	**CITY**		**ZIP CODE**		
PHONE	**RACE**		**HISPANIC?** Yes No		
Is this patient a contact to another known Varicella case? **Name of contact:** **Phone:**	**Was the patient hospitalized?** Yes No		**Did the patient have a fever?** Yes No **Date:**		
Was lab testing done for Varicella? Yes No **Lab test: DFA PCR IgM IgG Other** **Date:**____ **Result:** **Ordering Physician:**	**Number of lesions in total:** *(circle number of lesions)* <50 50-249 250-499 500+		**Did the patient attend daycare/after school care?** Yes No **Name of Facility:**		

Onset Date ____/____/____ **Last day of school attended** ____/____/____	**History of Disease**? Yes No **Date of Disease**____/____/____ **Vaccinated against Varicella?** Yes No **Number of Doses Received?** 1 2 **Date(s) Varicella Vaccine Administered:** (1)____/____/____(2)____/____/____				
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ADDRESS	**CITY**		**ZIP CODE**		
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Is this patient a contact to another known Varicella case? **Name of contact:** **Phone:**	**Was the patient hospitalized?** Yes No		**Did the patient have a fever?** Yes No **Date:**		
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Name of Person Reporting:_____ **PHONE:** _____

Agency/Organization Name: _____

Address: _____

CITY: _____ **ZIP:**_____ **COUNTY:**_____

DATE REPORTED: _____

REVISED 7/16