17639

Rev. 8/2017

Massachusetts Department of Public Health
Bureau of Infectious Disease
305 South Street, Room 563, Jamaica Plain, MA 02130
Phone: 617-983-6800 Confidential Fax: 617-983-6220

Received in Surveillance: __ / __ / ____

Varicella (Chickenpox) Cluster Reporting Form

Report Date: (mm/dd/yyyy) __ / __ / ____ **Facility Name:**

Address:

City: **St:** **ZIP:** **Facility Type:** ☐ School ☐ Hospital ☐ Other

Specify: ________

Reporter: **Phone:** ( ) -

CASE INFORMATION

First Name: **Last Name:** **DOB:** / /

Address: **City:**

St: **ZIP:** **Phone:** ( ) - **Rash Onset Date:** / /

# of Lesions: ☐ <50 ☐ 50-249 ☐ 250-500 ☐ >500 ☐ Unk **Fever:** ☐ Yes ☐ No ☐ Unk

Vaccinated? ☐ Yes ☐ No ☐ Unk **Dose 1:** / / **Dose 2:** / /

Diagnosing Provider: *(If applicable)* **Provider Phone:** ( ) -

First Name: **Last Name:** **DOB:** / /

Address: **City:**

St: **ZIP:** **Phone:** ( ) - **Rash Onset Date:** / /

# of Lesions: ☐ <50 ☐ 50-249 ☐ 250-500 ☐ >500 ☐ Unk **Fever:** ☐ Yes ☐ No ☐ Unk

Vaccinated? ☐ Yes ☐ No ☐ Unk **Dose 1:** / / **Dose 2:** / /

Diagnosing Provider: *(If applicable)* **Provider Phone:** ( ) -

First Name: **Last Name:** **DOB:** / /

Address: **City:**

St: **ZIP:** **Phone:** ( ) - **Rash Onset Date:** / /

# of Lesions: ☐ <50 ☐ 50-249 ☐ 250-500 ☐ >500 ☐ Unk **Fever:** ☐ Yes ☐ No ☐ Unk

Vaccinated? ☐ Yes ☐ No ☐ Unk **Dose 1:** / / **Dose 2:** / /

Diagnosing Provider: *(If applicable)* **Provider Phone:** ( ) -

Make solid marks that fit in the response boxes. Please use black or blue ink. **Right way ->** AB **Wrong way ->** A B

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