



## VARICELLA (chickenpox) Reporting Form

**Please use this form to report cases of varicella to the Brazos County Health Department at the end of every week. Phone (979) 361-4440, Fax (979) 823-2275**

<b>ONSET DATE</b>	<b>VACCINATED AGAINST VARICELLA?</b> Yes    No <b>Number of Doses Received?</b> 1    2 Date(s) Varicella Vaccine Administered:    ____ / ____ / ____ , ____ / ____ / ____			
<b>LAST NAME</b>	<b>FIRST</b>	<b>DOB</b>	<b>SEX</b>	<b>RACE</b>
<b>ADDRESS</b>	<b>CITY</b>	<b>ZIP CODE</b>	<b>HISPANIC?</b> Yes                  No	

<b>ONSET DATE</b>	<b>VACCINATED AGAINST VARICELLA?</b> Yes    No <b>Number of Doses Received?</b> 1    2 Date(s) Varicella Vaccine Administered:    ____ / ____ / ____ , ____ / ____ / ____			
<b>LAST NAME</b>	<b>FIRST</b>	<b>DOB</b>	<b>SEX</b>	<b>RACE</b>
<b>ADDRESS</b>	<b>CITY</b>	<b>ZIP CODE</b>	<b>HISPANIC?</b> Yes                  No	

<b>ONSET DATE</b>	<b>VACCINATED AGAINST VARICELLA?</b> Yes    No <b>Number of Doses Received?</b> 1    2 Date(s) Varicella Vaccine Administered:    ____ / ____ / ____ , ____ / ____ / ____			
<b>LAST NAME</b>	<b>FIRST</b>	<b>DOB</b>	<b>SEX</b>	<b>RACE</b>
<b>ADDRESS</b>	<b>CITY</b>	<b>ZIP CODE</b>	<b>HISPANIC?</b> Yes                  No	

<b>ONSET DATE</b>	<b>VACCINATED AGAINST VARICELLA?</b> Yes    No <b>Number of Doses Received?</b> 1    2 Date(s) Varicella Vaccine Administered:    ____ / ____ / ____ , ____ / ____ / ____			
<b>LAST NAME</b>	<b>FIRST</b>	<b>DOB</b>	<b>SEX</b>	<b>RACE</b>
<b>ADDRESS</b>	<b>CITY</b>	<b>ZIP CODE</b>	<b>HISPANIC?</b> Yes                  No	

**AGENCY REPORTED BY:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **COUNTY:** \_\_\_\_\_

**DATE REPORTED:** \_\_\_\_\_