

**BRANCH-HILLSDALE-ST. JOSEPH COMMUNITY HEALTH AGENCY**

**WEEKLY COMMUNICABLE DISEASE REPORT**

Schools play an essential role in reporting communicable diseases in the community. According to the State of Michigan Public Health Code (Public Act 368, of 1978 as amended), the local Health Department shall be notified of reportable communicable diseases.

\*\*\*\*\* **EVERY FRIDAY BEFORE 10:00 a.m.** \*\*\*\*\*

Please either FAX a copy to: **(269) 273-2452** OR mail a paper copy to:

St. Joseph CHA  
1110 Hill Street  
Three Rivers, Michigan  
49093  
**Phone: 269-273-2161**  
Ex: 241 or 207

**YOUR SCHOOL'S ILLNESS INFORMATION IS VERY IMPORTANT!**  
\*\*\*\*\* **PLEASE FILL OUT ALL SECTIONS, IF INDICATED** \*\*\*\*\*

**Section 1:** \*\*\* **(Circle facility type below AND write facility name)** \*\*\*

Week Ending Friday \_\_\_/\_\_\_/200\_\_ School / Pre-School / Daycare \_\_\_\_\_ District \_\_\_

Date \_\_\_\_\_ Submitted By \_\_\_\_\_ Telephone \_\_\_\_\_ Enrollment \_\_\_\_\_ **Nothing to report**

**Section 2:**

\*\* *If more space is needed, please attach additional forms* \*\*

**Please call the Health Department within 24 hrs. at the # listed above by our address, if ANY of the following are *suspected OR confirmed*:**  
**Measles, Mumps, Rubella (German Measles), Pertussis (Whooping Cough), Meningitis (viral or bacterial), Hepatitis A or B, Tuberculosis (TB), Haemophilus Influenzae-type B, Encephalitis OR if an unusual occurrence or outbreak of ANY disease / infection occurs.** NOTE: *Any case of Chicken Pox is to be reported using a copy of the form on the back of this page.*

Name	Date First Absent	Disease	Phone	DOB and Sex	Grade	Address	Diagnosed by: i.e. Dr., Parent, Teacher

**Section 3:**

**TOTAL # of Cases**

**DEFINITION**

**Influenza - Like Illness (Respiratory Flu)**

Any child with bronchitis, pneumonia or cold ***with fever*** and any of the following symptoms: sore throat, cough, generalized aching in the back or limb muscles.  
\*\*\*\* ***Vomiting and diarrhea alone is NOT respiratory flu.***\*\*\*\*

**Gastrointestinal Illness ("Stomach Flu ")**

Any child with vomiting and/or diarrhea for 24 to 48 hours (24-hr. flu, winter vomiting disease or suspected /confirmed norovirus)

**Unknown Influenza (Flu )**

Parent reports, "My child has the Flu" **AND** no other symptom information is available

**Section 4:** Please include the **NUMBER** of these cases. **Do not** list individually in Section 2

Cold- <i>no fever</i>	_____	Ring Worm	_____
Fifth Disease	_____	Scabies	_____
Impetigo	_____	Scarlet Fever	_____
Lice	_____	Sore Throat (only)	_____
Mononucleosis	_____	Strep Throat (Dr. diagnosed)	_____
Pink Eye	_____	Other (please describe):	_____

**Section 5:**

**Did school close this week due to excessive absences?**  
**Yes      No**

v. 05-06 Rev. 8-08

PLEASE FAX CASE REPORTS OF CHICKEN POX ***IMMEDIATELY*** UPON KNOWN DIAGNOSIS USING VARICELLA CASE REORT FORM ON REVERSE SIDE OF THIS MAIN REPORTING FORM

**BRANCH-HILLSDALE-ST. JOSEPH COMMUNITY HEALTH AGENCY**  
**VARICELLA ( CHICKEN POX ) CASE REPORT FORM**

CASE NAME: FIRST \_\_\_\_\_ LAST \_\_\_\_\_

COMPLETE ADDRESS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HOME PHONE NUMBER: (     ) \_\_\_\_\_

ALT. PHONE NUMBER: (     ) \_\_\_\_\_

SEX: \_\_\_\_\_ RACE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

PARENT NAME: FIRST \_\_\_\_\_ LAST \_\_\_\_\_

NAME & ADDRESS OF SCHOOL: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PHONE # OF SCHOOL: (     ) \_\_\_\_\_ EXTENSION: \_\_\_\_\_

STUDENT'S GRADE: \_\_\_\_\_ 1st DATE ABSENT: \_\_\_\_\_

PERSON PROVIDING INFORMATION: \_\_\_\_\_

PHONE # : (     ) \_\_\_\_\_ EXTENSION: \_\_\_\_\_

DIAGNOSED BY: \_\_\_\_\_ DATE DIAGNOSED: \_\_\_\_\_

PHONE # : (     ) \_\_\_\_\_

DATE VARICELLA VACCINE(S) RECEIVED: \_\_\_\_\_

**NOTE: YOU CAN FAX THIS OR E-MAIL TO:**

Sandi Miller  
Community Health Agency  
Coldwater Office  
Fax: 517-278-2923  
E-mail: [millers@bhsj.org](mailto:millers@bhsj.org)