

**DEKALB COUNTY SCHOOL DISTRICT STUDENT HEALTH SERVICES  
REPORT OF A COMMUNICABLE DISEASE(S)**

Please call and give this information to Student Health Services at (678) 676-1980  
Fax completed form to Marilyn Seaver, Clerical Assistant, at (678) 676-1981

School: \_\_\_\_\_ School Phone Number: \_\_\_\_\_

Principal: \_\_\_\_\_ Date: \_\_\_\_\_

Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_

Person completing form: Name \_\_\_\_\_ Title \_\_\_\_\_

Disease/Illness:

\_\_\_\_\_ Hepatitis A  
\_\_\_\_\_ Measles  
\_\_\_\_\_ MRSA  
\_\_\_\_\_ Mumps  
\_\_\_\_\_ Rubella  
\_\_\_\_\_ Pertussis  
\_\_\_\_\_ TB  
\_\_\_\_\_ Meningitis  
\_\_\_\_\_ Chickenpox

Only Report if 3 or More

\_\_\_\_\_ Strep Throat/Scarlet Fever  
\_\_\_\_\_ MRSA  
\_\_\_\_\_ Shigella  
\_\_\_\_\_ Salmonella  
\_\_\_\_\_ Norovirus "stomach flu"  
\_\_\_\_\_ Influenza  
\_\_\_\_\_ Other (specify): \_\_\_\_\_

Person's title who reported illness: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Student's name: \_\_\_\_\_ Home number: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Last Date of School Attendance: \_\_\_\_\_

Parent's name: \_\_\_\_\_ Work/ Cell #: \_\_\_\_\_

Student's address: \_\_\_\_\_ Zip code: \_\_\_\_\_

Was illness diagnosed by a physician? Yes \_\_\_\_\_ No \_\_\_\_\_

Physician name: \_\_\_\_\_

Physician phone number: \_\_\_\_\_

If student hospitalized, where: \_\_\_\_\_

Does the child have any immunodeficiency disorders? Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
This form is to be used by the principal/ school nurse/ nurse consultant in order to obtain and report communicable disease information. All of the above information is **strictly confidential**.

**For use by Student Health Services only:**

**Revised 01/2013**

**Date/Time faxed to DeKalb County Board of Health**

\_\_\_\_\_/\_\_\_\_\_ faxed by: \_\_\_\_\_

**Is this a cluster?** \_\_\_\_\_ **How many are apart of this cluster?** \_\_\_\_\_