

PERTUSSIS CASE REPORT

This form has been renumbered and revised. Please update your link with the following:

<http://dhs.wisconsin.gov/forms/F4/F44236.pdf>

VACCINE HISTORY

Complete Only for Children Ages <15 Years					
Vaccinated with DTP or DTaP Vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
	<u>Vaccination Date</u>	<u>Type</u>	<u>Vaccine Type Codes</u>	<u>Manufacturer</u>	<u>Manufacturer Codes</u>
1.	_____	1. _____	W = DTP Whole Cell	1. _____	C = Connaught (Aventis)
2.	_____	2. _____	A = DTaP	2. _____	L = Lederle (N/A)
3.	_____	3. _____	D = DT or Td	3. _____	S = SmithKline, Glaxo
4.	_____	4. _____	T = DTaP/Hib	4. _____	N = North American
5.	_____	5. _____	P = Pertussis only	5. _____	M = Massachusetts HD
6.	_____	6. _____	O = Other	6. _____	I = Michigan HD
			U = Unknown		O = Other
					U = Unknown
Reason not vaccinated with ≥ 3 doses of pertussis vaccine:					
		<input type="checkbox"/> 1. Religious exemption	<input type="checkbox"/> 4. Previous pertussis confirmed	<input type="checkbox"/> 7. Other	
		<input type="checkbox"/> 2. Medical contraindication	<input type="checkbox"/> 5. Parental refusal	<input type="checkbox"/> 9. Unknown	
		<input type="checkbox"/> 3. Philosophical exemption	<input type="checkbox"/> 6. Age <7 months		

Note: Record type and manufacturer codes for children 2 months through 6 years of age.

TREATMENT

Were antibiotics given? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
First antibiotic received:	Check (✓) One
Date started: _____	<input type="checkbox"/> 1. Erythromycin (includes Pediazole, ilosone) <u>recommended</u>
Number of days taken: _____	<input type="checkbox"/> 2. Trimethoprin-Sufamethoxazole ((bactrim/septra, TMP-SMZ)) <u>recommended</u>
	<input type="checkbox"/> 3. Clarithromycin/azithromycin <u>recommended</u>
	<input type="checkbox"/> 4. Tetracycline/Doxycycline
	<input type="checkbox"/> 5. Amoxicillin/Penicillin/Ampicillin/Augmentin/Ceclor/Cefixime
	<input type="checkbox"/> 6. Other _____
	<input type="checkbox"/> 9. Unknown
Second antibiotic received:	Check (✓) One
Date started: _____	<input type="checkbox"/> 1. Erythromycin (includes Pediazole, ilosone) <u>recommended</u>
Number of days taken: _____	<input type="checkbox"/> 2. Trimethoprin-Sufamethoxazole (bactrim/septra, TMP-SMZ)) <u>recommended</u>
	<input type="checkbox"/> 3. Clarithromycin/azithromycin <u>recommended</u>
	<input type="checkbox"/> 4. Tetracycline/Doxycycline
	<input type="checkbox"/> 5. Amoxicillin/Penicillin/Ampicillin/Augmentin/Ceclor/Cefixime
	<input type="checkbox"/> 6. Other _____
	<input type="checkbox"/> 9. Unknown

SOURCE

Possible SOURCE for this Case (for LHD use)					
Name	Age	Address	Telephone Number	Name of School, Daycare, Employer	Cough Onset Date

What is the Source Setting(s) of this Case?

<input type="checkbox"/> 1 Daycare	<input type="checkbox"/> 6 Hospital Outpatient Clinic	<input type="checkbox"/> 11 Military
<input type="checkbox"/> 2 School Work	<input type="checkbox"/> 7 Home	<input type="checkbox"/> 12 Correctional Facility
<input type="checkbox"/> 3 Doctor's Office	<input type="checkbox"/> 8 Work	<input type="checkbox"/> 13 Church
<input type="checkbox"/> 4 Hospital Ward	<input type="checkbox"/> 9 Unknown	<input type="checkbox"/> 14 International Travel
<input type="checkbox"/> 5 Hospital ER	<input type="checkbox"/> 10 College	<input type="checkbox"/> 15 Other