



## REPORTING OF COMMUNICABLE DISEASES IN THE SCHOOL SETTING

Principals of schools, school nurses and/or their designee(s) are among those persons identified as being required to report communicable diseases to the local health department as per Wisconsin Statute Chapter 252.05 and Administrative Rule Chapter HFS 145.

In Sheboygan County, communicable diseases should be reported to the Sheboygan County Department of Health and Human Services, Division of Public Health, by phone at **920-459-4382 or 1-800-596-1919, ext 4382, by fax at 920-459-0529, or after hours at 920-946-7953.**

Specific diseases that must be reported to the Health Department are listed on the [State of Wisconsin Acute & Communicable Disease Case Report Form](#). A copy of this form can be found on the next two pages or at <http://www.dhs.wisconsin.gov/forms/F4/F44151.pdf>. Following the receipt of communicable disease reports, Public Health staff will initiate appropriate public health follow-up and disease control interventions.

**\*In addition to the diseases listed on the required case report form referenced above, clusters of illness (i.e. absentee rates of greater than 10% among students and/or staff) should be reported directly to the Health Department via the contact numbers listed above.**

School administrators are encouraged to alert all school staff regarding the school's responsibility to report communicable diseases to the local health department.

**ACUTE & COMMUNICABLE DISEASE CASE REPORT**

Information for completing this form on reverse side

<b>DEMOGRAPHIC DATA PATIENT INFORMATION</b>	<b>Case Identification for all Category I and II Diseases</b>				
	Patient's Name (Last) (First) (M.I.)		Date of Birth (mm/dd/yyyy)	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
	Patient's Address		City	State	Zip Code
	County of Residence		Home Telephone ( ) ( )	Work Telephone ( ) ( )	
	Patient's Parent / Guardian if patient is a minor (not needed for STD)		Patient's Employer & Occupation or School, Day Care, Institution		
<b>MORBIDITY DATA</b>	Race: <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other Specify: _____		Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino		
	Patient Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Due date (mm/dd/yyyy)	Patient Died of This Illness? <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Disease / Organism	Date of Onset <input type="checkbox"/> Asymptomatic	Specimen Type	Outbreak Related? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Underlying Medical Condition? <input type="checkbox"/> Unknown <input type="checkbox"/> Yes, specify: _____ <input type="checkbox"/> No
Lab data (test name, test date, test result; include confirmatory tests)			Immunization data (immunization name and date(s))		
<b>SEXUALLY TRANSMITTED DISEASES</b>	Complete appropriate section for specific disease(s)				
	<input type="checkbox"/> Syphilis <input type="checkbox"/> Primary (chancere present) <input type="checkbox"/> Secondary (skin lesions, rash, etc.) <input type="checkbox"/> Early Latent (asymptomatic, < 1 yr) <input type="checkbox"/> Late Latent (over 1 yr duration) <input type="checkbox"/> Neurosyphilis <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Other <input type="checkbox"/> Congenital		<input type="checkbox"/> Gonorrhea <input type="checkbox"/> Chlamydia <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Uncomplicated Urogenital (Urethritis, Cervicitis) <input type="checkbox"/> Salpingitis (PID) <input type="checkbox"/> Ophthalmia/Conjunctivitis <input type="checkbox"/> Other (Arthritis, skin lesions, etc.) <input type="checkbox"/> Resistant Gonorrhea <input type="checkbox"/> Penicillinase-Producing <input type="checkbox"/> Other		<input type="checkbox"/> Chancroid
	Type and Amount of Treatment		For all STDs: Has patient been treated? <input type="checkbox"/> Yes <input type="checkbox"/> No Date(s) of Treatment (mm/dd/yyyy)		
<b>ENTERIC DISEASES AND HEPATITIS</b>	Campylobacter, Cryptosporidia, E. coli, Giardia, Hepatitis A, Salmonella, Shigella, Yersinia		<b>Hepatitis B and C Laboratory Results</b>		
	Check below if patient: Yes No Unknown <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> is a food handler. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> attends or works at a day care center. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> is a health care worker. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> is in contact with animals. Specify animal: _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> drinks unpasteurized milk. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> traveled out-of-state. Location / dates: _____		Other: _____ HBsAg <input type="checkbox"/> Positive <input type="checkbox"/> Negative anti-HBs <input type="checkbox"/> Positive <input type="checkbox"/> Negative anti-HBc <input type="checkbox"/> Positive <input type="checkbox"/> Negative anti-HBc-IgM <input type="checkbox"/> Positive <input type="checkbox"/> Negative HepC-EIA <input type="checkbox"/> Positive <input type="checkbox"/> Negative HepC-RIBA <input type="checkbox"/> Positive <input type="checkbox"/> Negative HepC-PCR <input type="checkbox"/> Positive <input type="checkbox"/> Negative		
<b>TUBERCULOSIS</b>	<b>Mycobacteriology</b>		<b>Chest X-ray and CT Scan</b>		<b>Tuberculin Test</b>
	Specimen type and date collected (mm/dd/yyyy)		<b>Chest Xray</b> <input type="checkbox"/> Not done <input type="checkbox"/> Unknown <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal For abnormal CXR: Evidence of cavity <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Evidence of miliary TB <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<b>Mantoux</b> <input type="checkbox"/> Not Done Date Done (mm/dd/yyyy) Result (mm induration) <input type="checkbox"/> Positive _____ mm <input type="checkbox"/> Negative _____ mm If negative, anergic? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Blood Assay</b> Date Done: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate
	Smear <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending <input type="checkbox"/> Not done Nucleic acid amplification <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending <input type="checkbox"/> Not done <input type="checkbox"/> Indeterminate Culture <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending <input type="checkbox"/> Not done If culture positive: <input type="checkbox"/> M. tuberculosis complex <input type="checkbox"/> Atypical Mycobacteria, Specify: _____		<b>Chest CT or other imaging study:</b> <input type="checkbox"/> Not done <input type="checkbox"/> Unknown <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal For abnormal CT or other study: Evidence of cavity <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Evidence of miliary TB <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Treatment <input type="checkbox"/> Isoniazid <input type="checkbox"/> Rifampin <input type="checkbox"/> Pyrazinamide <input type="checkbox"/> Ethambutol <input type="checkbox"/> Other, specify: _____ Date started (mm/dd/yyyy)
Patient's country of origin	Date arrived in U.S.	Date/time called to local public health (mm/dd/yyyy, hour)			
<b>VARICELLA AND COMMENTS</b>	Varicella Severity Estimate: <input type="checkbox"/> Mild (<50 lesions) <input type="checkbox"/> Moderate (Approx. 50-499 lesions) <input type="checkbox"/> Severe (Approx. 500+ lesions)				
	Epi-Linked to Another Varicella Case? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Epi-Linked Case Name: _____				
Comments:			Date rec'd by LHD	Date sent to DPH	
<b>REPORTING SOURCE (REQUIRED)</b>	Agency Reporting (Name & Address)		Date reported	Telephone No. ( ) ( )	
	Attending Physician (Name & Address)		Interviewer Initials	Date of Interview Physician Telephone No. ( ) ( )	

## Information for Completing ACUTE AND COMMUNICABLE DISEASE CASE REPORT

### WISCONSIN STATUTE CHAPTER 252.05 AND ADMINISTRATIVE RULE CHAPTER HFS 145 REQUIRE REPORTING OF COMMUNICABLE DISEASES.

Persons required to report include any person licensed under ch. 441 and 448, Wis. Stats., or any other person having knowledge that a person has a communicable disease such as:

- A person in charge of infection control at a health care facility
- Laboratory directors
- School nurses, principals of schools and day care center directors

For further information see Wisconsin Administrative Rule HFS 145.

Diseases listed under categories I and II are to be reported to the local city or county health officer located in the local public health department of the patient's place of residence. Category III conditions must be reported directly to the state epidemiologist. Complete the "Demographic Data", "Morbidity Data" and "Reporting Source" sections for ALL diseases. For diseases preceded by an asterisk (\*), provide immunization history. Follow-up epidemiologic information may be requested by local or state public health officials. Send copy "A" and copy "B" to the local health officer. Copy "C" may be retained with the patient's record.

### REPORT THE FOLLOWING DISEASES TO YOUR LOCAL HEALTH AGENCY

#### CATEGORY I:

The following diseases are of urgent public health importance and shall be reported IMMEDIATELY by telephone or fax to the patient's local health officer upon identification of a case or suspected case. In addition to the immediate report, within 24 hours complete and mail an Acute and Communicable Diseases Case Report (DPH 4151) or enter the report into the Wisconsin Electronic Disease Surveillance System. Public health intervention is expected as indicated. See s. HFS 145.04 (3) (a).

Anthrax <sup>1,4,5</sup>	Hantavirus infection <sup>1,2,4,5</sup>	*Pertussis (whooping cough) <sup>1,2,3,4,5</sup>	Severe Acute Respiratory Syndrome-associated Coronavirus (SARS-CoV) <sup>1,2,3,4</sup>	Yellow fever <sup>1,4</sup>
Botulism <sup>1,4</sup>	*Hepatitis A <sup>1,2,3,4,5</sup>	Plague <sup>1,4,5</sup>	Smallpox <sup>4,5</sup>	Any illness caused by an agent that is foreign, exotic or unusual to Wisconsin, and that has public health implications <sup>4</sup>
Botulism, infant <sup>1,2,4</sup>	*Measles <sup>1,2,3,4,5</sup>	*Poliovirus infection (paralytic or nonparalytic) <sup>1,4,5</sup>	Tuberculosis <sup>1,2,3,4,5</sup>	
Cholera <sup>1,3,4</sup>	Meningococcal disease <sup>1,2,3,4,5</sup>	Rabies (human) <sup>1,4,5</sup>	Vancomycin-intermediate Staphylococcus aureus (VISA) and Vancomycin-resistant Staphylococcus aureus (VRSA) infection <sup>1,4,5</sup>	
*Diphtheria <sup>1,2,4,5</sup>	Outbreaks, foodborne or waterborne <sup>1,2,3,4</sup>	Ricin toxin <sup>4,5</sup>		
*Haemophilus influenzae invasive disease, (including epiglottitis) <sup>1,2,3,5</sup>	Outbreaks, suspected, of other acute or occupationally-related diseases	*Rubella <sup>1,2,4,5</sup>		
		*Rubella (congenital syndrome) <sup>1,2,5</sup>		

#### CATEGORY II:

The following diseases shall be reported to the local health officer on an Acute and Communicable Disease Case Report (DPH 4151) or by other means or by entering the data into the Wisconsin Electronic Disease Surveillance System within 72 hours of the identification of a case or suspected case. See s. HFS 145.04 (3) (b).

Arboviral disease <sup>1,2,4</sup>	*Hepatitis B <sup>1,2,3,4,5</sup>	Meningitis, bacterial (other than Haemophilus influenzae, meningococcal or streptococcal, which are reportable as distinct diseases) <sup>2</sup>	Streptococcal disease (all invasive disease caused by Groups A and B streptococci)
Babesiosis <sup>4,5</sup>	Hepatitis C <sup>1,2</sup>	*Mumps <sup>1,2,4,5</sup>	Streptococcus pneumoniae invasive disease (invasive pneumococcal) <sup>1</sup>
Blastomycosis <sup>5</sup>	Hepatitis D <sup>2,3,4,5</sup>	Mycobacterial disease (nontuberculous)	*Tetanus <sup>1,2,5</sup>
Brucellosis <sup>1,4</sup>	Hepatitis E <sup>3,4</sup>	Psittacosis <sup>1,2,4</sup>	Toxic shock syndrome <sup>1,2</sup>
Campylobacteriosis (campylobacter infection) <sup>3,4</sup>	Histoplasmosis <sup>5</sup>	Pelvic inflammatory disease <sup>2,5</sup>	Toxic substance related diseases:
Chancroid <sup>1,2,4,5</sup>	Influenza-associated pediatric death <sup>1,2</sup>	Q Fever <sup>4,5</sup>	Infant methemoglobinemia
Chlamydia trachomatis infection <sup>1,2,4,5</sup>	Influenza A virus infection, novel subtypes <sup>1,2</sup>	Rheumatic fever (newly diagnosed and meeting the Jones criteria) <sup>5</sup>	Lead intoxication (specify Pb levels)
Cryptosporidiosis <sup>1,2,3,4</sup>	Kawasaki disease <sup>2</sup>	Rocky Mountain spotted fever <sup>1,2,4,5</sup>	Other metal and pesticide poisonings
Cyclosporiasis <sup>1,4,5</sup>	Legionellosis <sup>1,2,4</sup>	Salmonellosis <sup>1,3,4</sup>	Toxoplasmosis
Ehrlichiosis (anaplasmosis) <sup>1,5</sup>	Leprosy (Hansen Disease) <sup>1,2,3,4,5</sup>	Syphilis <sup>1,2,4,5</sup>	Transmissible spongiform encephalopathy (TSE, human; CJD)
E. coli O157:H7, other Shiga toxin-producing E. coli (STEC), enteropathogenic E. coli, enteroinvasive E. coli, and enterotoxigenic E. coli <sup>1,2,3,4</sup>	Leptospirosis <sup>4</sup>	Shigellosis <sup>1,3,4</sup>	Trichinosis <sup>1,2,4</sup>
Giardiasis <sup>3,4</sup>	Listeriosis <sup>2,4</sup>		Tularemia <sup>4</sup>
Gonorrhea <sup>1,2,4,5</sup>	Lyme disease <sup>1,2</sup>		Typhoid fever <sup>1,2,3,4</sup>
Hemolytic uremic syndrome <sup>1,2,4</sup>	Lymphocytic Choriomeningitis Virus (LCMV) infection <sup>4</sup>		*Varicella (chickenpox) <sup>1,3,5</sup>
	Malaria <sup>1,2,4</sup>		Vibriosis <sup>1,3,4</sup>
			Yersiniosis <sup>3,4</sup>

#### CATEGORY III:

The following diseases shall be reported to the state epidemiologist on an AIDS case report (DPH 4264) or a Wisconsin Human Immunodeficiency Virus (HIV) Infection Confidential Case Report (DPH 4338) or by other means within 72 hours after identification of a case or suspected case. See s. 252.15 (7) (b), Stats., and s. HFS 145.04 (3) (b).

Acquired Immune Deficiency Syndrome (AIDS)<sup>1,2,4</sup>  
Human immunodeficiency virus (HIV) infection<sup>2,4</sup>  
CD4+ T-lymphocyte <200/uL, or CD4+ T-lymphocyte percentage of total lymphocytes <14

#### KEY:

<sup>1</sup>For diseases preceded by an (\*), indicate immunization history in the "Immunization data" box in the "Morbidity data" section.

<sup>2</sup>Infectious diseases designated as notifiable at the national level.

<sup>3</sup>Wisconsin or CDC follow-up form is required. Local health departments have templates of these forms in the EpiNet manual.

<sup>4</sup>Risk assessment by local health department is needed to determine if patient or member of patient's household is employed in food handling, day care or health care.

<sup>5</sup>Case investigation by local health department is needed.

<sup>6</sup>Immediate treatment is recommended, i.e., antibiotic or biologic for the patient or contact or both.