New Jersey Department of Health

KAWASAKI SYNDROME REPORT

Date	CDRS ID No.

Name (Last)	(First)	(MI)	Sex	Date of Birth (Age)

Street Address	County

City	State	Zip Code	Telephone Number

Race

☐White ☐American Indian ☐Unknown/Other
☐Black ☐Asian

Ethnicity

☐Hispanic ☐Unknown
☐Non-Hispanic

Reporting Physician (Name, Address and Telephone No.)	Hospital (Name, Address and Telephone No.)

Date of Diagnosis	**Onset Date of Illness**	**Deceased?**	Case Status
____ / ____ / ____	____ / ____ / ____	☐Yes ☐No ☐Unknown	☐Possible ☐Probable ☐Confirmed

Clinical:

Fever (of greater than, or equal to 5 days' duration)? ☐ Yes ☐ No

Conjunctival injection, bilateral? ☐ Yes ☐ No

Oral changes (erythema of lips or oropharynx, strawberry tongue, or fissuring of the lips)? ☐ Yes ☐ No

If yes, specify location and type of change: _____

_____

Peripheral extremity changes (edema, erythema of palms and soles, or generalized and/or periungual desquamation)? ☐ Yes ☐ No

If yes, specify: _____

Cervical lymphadenopathy? ☐ Yes ☐ No

Rash? ☐ Yes ☐ No

If yes, specify location: _____

_____

Other conditions were excluded?

Toxic shock:	☐ Yes	☐ No	**Rickettsial diseases:**	☐ Yes	☐ No
Scalded skin syndrome:	☐ Yes	☐ No	**Drug reactions:**	☐ Yes	☐ No
Scarlet fever:	☐ Yes	☐ No			

If no, specify: _____

Comments:

Name and Title of Person Submitting Report	Telephone Number