Documentation of Varicella (Chickenpox) Disease

(To be filled out by the parent, guardian, or medical provider of the child / student)

This form is used **ONLY** if child **HAD** the **Chickenpox DISEASE**

This document is being submitted on behalf of: *(Name of child / student)*

_____

First *Middle* *Last*

_____/____/_____

(Birthdate of child / student) mm/dd/yyyy

I, _____ , verify that the above listed

Parent/Guardian/Medical Provider

Child / student **HAD** the **Varicella DISEASE** in _____ (*year*).

THIS FORM NOT NEEDED IF CHILD HAD SHOT

_____

(Signature of parent/guardian/medical provider)

_____

(Date)