

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)