

(School/School District Name)

VARICELLA (Chickenpox) IMMUNITY STATEMENT

Name: _____ D. O. B. _____

Check one of the following boxes regarding Varicella (Chickenpox) Immunity:

<input type="checkbox"/> Varicella Vaccine	Date Given:
<input type="checkbox"/> Varicella Lab Evidence	Date:
<input type="checkbox"/> Varicella Disease	Age of child or date when he/she had chickenpox disease:

Signature: _____ Date: _____

Circle one: parent, guardian, healthcare provider