DOCUMENTATION OF VARICELLA (CHICKEN POX) DISEASE

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

This document is being submitted on behalf of:

_____ / / _____

Name of child/student Birth Date (mm/dd/yyyy)

I _____ verify that the above listed child/student had the
Parent/Guardian/Medical Provider

varicella disease in _____ (year).

_____

Signature of parent/guardian/medical provider *Date*