<u>Documentation of Varicella (Chickenpox) Disease</u>

(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)*

____

First *Middle* *Last*

_______________ / _______ / _______________

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

I, ____ , verify that the above listed

Parent/Guardian/Medical Provider

Child / student **<u>had</u>** the **Varicella** disease in ______________ (*year*).

____

(Signature of parent/guardian/medical provider)

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(Date)