

Documentation of Chicken Pox (Varicella 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: _____

D.O.B _____

I _____ verify that the above listed
(Parent/Guardian/Medical Provider)

child/student had the varicella disease in _____.
(Year)

(Signature of (Parent/Guardian/Medical Provider)

(Date)