Documentation of Varicella (Chickenpox) 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 of child/student)

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

had the varicella disease in _____ (year).

_____

(Signature of parent/guardian/medical provider)