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
(Parent/Guardian/Medical Provider)

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

_____

(Signature of Parent/Guardian/Medical Provider)