VARICELLA (Chickenpox) IMMUNITY STATEMENT

Name:_____ Birthdate:_____
Please Print

Check one of the following boxes regarding Varicella (Chickenpox) Immunity:

☐ Varicella Vaccine Date Given:_____

☐ Varicella Lab Evidence Date: _____ Test:_____

☐ Varicella Disease Age of child when he/she had Chickenpox:_____

Name:_____
Licensed healthcare provider

Signature:_____ Date:_____