

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: _____