

WEST ALLEGHENY SCHOOL DISTRICT

VARICELLA (Chickenpox) IMMUNITY STATEMENT

Name: _____ D.O.B. _____

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

<input type="checkbox"/> Varicella Vaccine	Dates Given: #1 _____ #2 _____
<input type="checkbox"/> Varicella Lab Evidence	Date: _____
<input type="checkbox"/> Varicella Disease	Age of child or date when he/she had chickenpox disease: _____

Signature: _____ Date: _____
Healthcare Provider

PLEASE NOTE: THIS FORM MUST BE SIGNED BY YOUR CHILD'S HEALTH CARE PROVIDER.

RETURN COMPLETED FORM TO YOUR SCHOOL NURSE BY THE FIRST DAY OF SCHOOL.

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