

## **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:

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(Name of child/student) (Birth date of child/student)

I verify that the above listed child/student had the Varicella disease in \_\_\_\_\_ (year).

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(Signature of parent/guardian/medical provider)