

## 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  
Parent/Guardian/Medical Provider

had the varicella disease in \_\_\_\_\_ (year).

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(Signature of parent/guardian/medical provider)

Printed from the Nebraska Health and Human Services System Web site.  
[http://www.hhs.state.ne.us/imm/school\\_i.htm](http://www.hhs.state.ne.us/imm/school_i.htm)