WEST ALLEGHENY SCHOOL DISTRICT

A Tradition of Excellence . . . A Vision for Tomorrow

Varicella (Chickenpox) Immunity Statement

Name:_________________________________ D.O.B.____________________________

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

☐ Varicella Vaccine Dates Given: Dose #1_________ Dose #2________

☐ Varicella Lab Evidence Date:_______________________

☐ Varicella Disease Age of child or date when he/she had chickenpox disease:_____________________

Signature:____ Date:__________________
Healthcare Provider