SOUTH BUTLER COUNTY SCHOOL DISTRICT
Knoch Middle School
School Health Services

VARICELLA (Chickenpox) Immunity Statement

Name _____ Grade _____

Date of Birth _____

Please check one of the following and provide the requested information:

____ Varicella Vaccine (Chickenpox Immunization) Date Given _____

____ Chickenpox Disease (Varicella) Age when student had chickenpox ____.
Approximate Date of Illness _____
Month/Day/Year

____ Date of Chickenpox Disease on file in School Health office _____
I verify that my child did have Chickenpox disease and I agree with the date written.

____ Laboratory evidence of Chickenpox (Varicella) Disease Date _____
Proof from physician attached.

Signature _____ Date _____

Circle one: Parent, Guardian, or Healthcare Provider

PLEASE RETURN TO THE SCHOOL NURSE'S OFFICE