Varicella Verification Document

Facility/Medical Office Name: _____

Address: _____

City/St/Zip: _____

PATIENT NAME	First	Last
To Whom It May Concern: According to the above-referenced patient, he/she has previously had the disease of **VARICELLA** (Chicken Pox). Additional Remarks:		
Verified by a Doctor or a Nurse Practitioner:		Date
Title		Signature