



## VERIFICATION OF VARICELLA DISEASE

I, \_\_\_\_\_, do confirm that \_\_\_\_\_,  
Parent or Guardian's Name Child's Name  
had Varicella (Chickenpox) disease on or about \_\_\_\_\_.  
Date

The diagnosis of this disease **was / was not** confirmed by this child's health care practitioner.

Name of health care practitioner at that time:

\_\_\_\_\_  
(Optional)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent/guardian