HS0044
Rev. 11/05

VARICELLA (CHICKENPOX) DISEASE DOCUMENTATION
Health Services Department
Lincoln Public Schools

(To be filled out by the parent, guardian, or medical provider of the child/student)

This document is being submitted on behalf of:

Child/Student Name: _____

ID#: _____

I _____ verify that the above listed child/student had the varicella disease in _____ (year).

_____

(Signature of parent/guardian/medical provider) *Date*