Documentation of Varicella (Chickenpox) Disease or Immunization

Student Name _____ Date of Birth_____

School Name Select from list _____ Grade _____

Has your child ever had chickenpox? (please circle one answer) **Yes** (go to #1) **No** (go to #2) **Don't Recall** (go to #1)

1. **Please answer the following questions** (please circle one answer):
   a. Was your child in "face to face" contact with other children who had chickenpox? **Yes** **No** **Don't Recall**
   b. Did your child have a rash on his/her body? **Yes** **No** **Don't Recall**
   c. Did the rash "itch?" **Yes** **No** **Don't Recall**
   d. Were there blisters present? **Yes** **No** **Don't Recall**
   e. Did "scabs" appear toward the end of the rash? **Yes** **No** **Don't Recall**
   f. When did your child have chickenpox? (approximate date) _____/_____ **Month Year**
2. **If your child has not had chickenpox, has he/she had the chickenpox (varicella) shot?** **Yes** **No** **Don't Recall**
   (please circle one answer)

   If you circled **YES**, please take your child's immunization record to the school nurse so the date of the shot can be recorded in your child's health record.

   If you circled **No or Don't Recall**, please take your child to their doctor or to the local health clinic to get the chickenpox shot, then take their immunization record to the school nurse so the date can be recorded in your child's health record.

Parent/Guardian Name (please print) _____

Parent/Guardian Signature _____

Address _____

Daytime Telephone Number _____