

## VARICELLA STATUS

Name \_\_\_\_\_

Date \_\_\_\_\_

**Please complete one of the following options**

---

---

Option #1

I have had Chicken Pox either as a child or as an adult. The year that I had Chicken

Pox is \_\_\_\_\_  
Date

---

Nurse Signature

---

---

Option #2

**Varicella Titer**

\_\_\_\_\_ Immune  
Date

(Current within 10 years)

**COPIES OF TEST RESULTS MUST BE ATTACHED TO BE VALID**

---

---

Option #3

**Varicella Immunization**

\_\_\_\_\_ Date

(Current within 10 years)

**COPIES OF TEST RESULTS MUST BE ATTACHED TO BE VALID**