PARENT/PHYSICIAN'S VERIFICATION OF VARICELLA (CHICKENPOX) ILLNESS

This is to verify the person for whom this card was issued had:

☐ Varicella (chickenpox) illness on or about _____ and does not need the vaccine.

_____ Date

_____ Parent/Physician's Signature

HEARING @ 25 dB DATE: SIGNATURE:				
Hz	**1000**	**2000**	**4000**	☐ Pass
R				☐ Fail
L				
VISION DATE: SIGNATURE:				
R20/_____ L20/_____ Pass_____ Fail_____				

Privacy Notice: I acknowledge that I have received a copy of my immunization provider's HIPAA privacy notice.

Texas Department of State Health Services
Immunization Branch

Stock No. C-11
Revised 01/2013

School / Childcare Immunization Record

Name: _____ Sex: M F

Date of Birth: _____ Telephone No.: _____

Street Address: _____

City, State, Zip Code: _____

School: _____

Parent's Name: _____

Name: _____ Date of Birth: _____

VACCINES	DATE	DATE	DATE	DATE	DATE
Hepatitis B					
DTP/DTaP/DT					
Tdap/Td					
Td					
OPV, IPV					
Hib					
Pneumococcal					
Rotavirus					
HPV					
MMR					
Measles					
Hepatitis A					
Varicella					
Meningococcal					
Influenza					
Influenza					
Other					
Other					
Other					
TB Test	Date:		Result:		

Date:_____ Staff Signature: _____