Varicella Protection – Documentation

Student Name (Print)                                     UF-ID

Please indicate the method of protection against varicella infection by having a health care provider complete one of the options below:

Option 1

Varicella Vaccination #1  Date: ____________________
Varicella Vaccination #2  Date: ____________________

Option 2

Varicella Antibody Titer Results:  ____ Acceptable Protection  
Date: ________________  ____ Unacceptable Protection

Name of Healthcare Provider: ________________________________

Address: ________________________________________________

Signature of Healthcare Provider: ____________________________