The UNIVERSITY of VERMONT
COLLEGE OF NURSING & HEALTH SCIENCES

Name _____
Student ID# _____
Date of Birth _____
Program/Graduation Year _____
Phone# _____
Email _____

## Varicella

**Everything MUST be ENTIRELY filled out by your licensed health care provider on this UVM-provided form ONLY.**
**It is your responsibility to review your form for completeness.**
**COPIES OF MEDICAL RECORDS/LABS WILL NOT BE ACCEPTED.**

| **Varicella** | | | | **REQUIRED** |
|---|---|---|---|---|
| Date(s) of disease: _____ | **OR** | Dates of Varicella vaccine<br>Dose #1 date: _____<br>Dose #2 date: _____ | **AND** | Date and results of lab titer<br>Varicella titer date: _____<br>***circle result:*** pos neg indeterminate |

**Licensed Health Care Provider Attestation**

By signing below, I affirm that I am a licensed health care provider. I am aware that leaving any required fields blank will result in the student being **unable to progress in his/her major** at the University of Vermont.

Signature of **Licensed Health Care Provider** _____ **Credentials** _____ Date _____

Clinic Stamp or Printed Name of Provider _____ Provider Telephone Number _____

**It is MANDATORY that you submit form to CastleBranch.**

Please note, UVM Student Health will not submit your paperwork for you. You will need to pick up your form and submit it to CastleBranch.

The information included on this form maybe released to the infection control officer and clinical education coordinators at sites where you perform your clinical education experience.