PLATT COLLEGE

Standardized Immunization Form: Varicella Only

Patient Section

Last Name:		**First Name:**		**Middle Initial:**	
DOB:		**Street Address:**			
Last 4 SS#:		**City:**			
Phone:		**State:**			
Email:		**ZIP Code:**			

Below Section: MUST BE COMPLETED BY YOUR HEALTHCARE PROVIDER

Printed Name of Healthcare Provider:	
Title:	
Address Line 1:	
Address Line 2:	
City:	
State:	
ZIP Code:	
Phone:	
Fax:	
Email Contact:	

Authorized Signature of Healthcare Provider: _____

Date: _____

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Name: _____ **Date of Birth:** _____

(Last, First, Middle Initial) (mm/dd/yyyy)

Varicella (Chicken Pox) Vaccination – Two (2) doses of vaccine or positive serology			
Varicella Vaccination		Date	Documentation
	Varicella Vaccine Dose #1	_____/_____/_____	
	Varicella Vaccine Dose #2	_____/_____/_____	
	Serologic Immunity (IgG, antibodies, titer)	_____/_____/_____	Must Provide Documentation