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VERIFICATION OF DISEASE STATEMENT: VARICELLA-ZOSTER VIRUS (CHICKENPOX)
For Children Attending Schools and Child Caring Facilities

Wyo. Stat. Ann. §§ 21-4-309 and 14-4-116, requires any person attending, full or part time, any public or private school or child caring facility, to be immunized against the vaccine-preventable diseases designated by the State Health Officer.

This form must be completed by a physician, nurse practitioner, physician's assistant or physician's designee to serve as verification that a child has had the varicella-zoster virus.

Directions:

1. Only complete this form for a child that has had the **CHICKENPOX.**
2. Use one form per child.
3. A copy of this form must be returned to the Preschool/School/Child Caring Facility in which the child is enrolled.

Evidence of immunity in lieu of age-appropriate varicella vaccination includes any of the following:

- Laboratory evidence of immunity or laboratory confirmation of disease, or
- Diagnosis or verification of a history of varicella or herpes zoster by a health care provider.

To verify a history of varicella, health care providers should inquire about:

- An epidemiologic link to another typical varicella case or to a laboratory confirmed case, or
- Evidence of laboratory confirmation, if testing was performed at the time of acute disease.

Persons who have neither an epidemiologic link nor laboratory confirmation of varicella should not be considered as having a valid history of disease. For these persons, a second dose of vaccine is recommended if they previously received only one dose. If a health care provider verifies the diagnosis based on the above criteria, then vaccination is not needed.

Physician's Statement

Child's Full Name: ______________________________ **Date of Birth:** ______________

By signing this statement, I am verifying that the child named above had the varicella-zoster virus approximately on or about ____________________ and therefore does not need the
(date or year)
varicella vaccine. I understand that this document will be included in the child's permanent record.

______________________________ ______________________________
Printed Name of Health Care Provider **Signature**

____
Date