AUBURN UNIVERSITY

Harrison College of Pharmacy

Varicella (Chicken Pox)

Student Information:

Last Name First Name Middle Initial

Street Address City State Zip

Email Address _____ Phone ( )_____

Date of Birth _____ Male ( ) Female ( )

History of Disease	_____/_____/_____ Month Day Year	Minimum month/year accepted. Please provide lab evidence of immunity if date is not available

OR

Immunizations (Two doses required)	#1 _____/_____/_____ Month Day Year	#2 _____/_____/_____ Month Day Year

OR

Laboratory Evidence of Immunity *Must submit copy of lab report ** If not immune, please complete the vaccination series	_____/_____/_____ Month Day Year	Results: Immune or Non-Immune

MD/PA/NP Signature: _____ **Date:** _____

Print Name: _____

Address: _____

Phone: ( ) _____ - _____

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