



Department of Veterans Affairs
1670 Clairmont Road
Decatur, GA 30033

Varicella (Chickenpox) Guidelines & Waiver

Name: _____

School: _____

Faculty Name: _____

Location of Clinical: _____ Date of Clinical: _____

*Everyone must check one box below. Medical documentation must be provided to Nursing Education of: History of Chickenpox, Positive Varicella IgG, or Varicella vaccination.

- ☐ **I have provided documentation of physician-diagnosed Chickenpox disease with this packet.**
- ☐ **Vaccinated Student:**
I have been vaccinated with VARIVAX (two Varivax at least one month apart) and have provided the record with this packet.
- ☐ **I have provided documentation of a positive Varicella IgG blood test with this packet .**
- ☐ **I have received the two Varivax vaccinations, but I do not have documentation at this time.**

I understand that breakthrough infections (cases of chickenpox) have occurred among vaccinated individual after exposure to individuals with chickenpox disease. It is my responsibility to immediately notify Atlanta VAMC Employee Health Services of chickenpox exposures at or away from the facility.

Signature: _____

Date: _____