UF UNIVERSITY of FLORIDA
The Foundation for The Gator Nation

College of Pharmacy
Office for Student Affairs
HPNP Complex

PO Box 100495
Gainesville, Florida 32610
Tel: (352) 273-6217
Fax: (352) 273-6219

Varicella Protection – Documentation

Name of Student:
Campus Site:

Please indicate the method of protection against varicella infection by having a health care provider complete one of the options below:

Option 1

Varicella Vaccination #1 Date:

Varicella Vaccination #2 Date:

Option 2

Varicella Antibody Titer Results: ____ Acceptable Protection
____ Unacceptable Protection

Option 3

Receipt from healthcare provider of a diagnosis of chickenpox or herpes zoster:

____ I certify that the above individual has a diagnosis of varicella or herpes zoster illness in their medical record.

Please have the healthcare provider complete the requested information below and sign to attest that one of the above options is valid.

Name of Healthcare Provider:

Address:

Signature of Healthcare Provider: