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# Dentist Aide Program

## SWORN STATEMENT OF A HISTORY OF VARICELLA DISEASE

By my signature on this document, I \_\_\_\_\_, attest that

PRINT FULL LEGAL NAME

I have a personal history of varicella disease (chickenpox) or have varicella immunity.

Student Signature (exactly as printed above):

\_\_\_\_\_

Affix Notary Seal Below

Sworn to before me this \_\_\_\_\_ day of

\_\_\_\_\_, \_\_\_\_\_

Notary Public Signature:

\_\_\_\_\_

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