UNIVERSITY OF ALABAMA HOSPTAL
RECORD FOR VARICELLA VIRUS VACCINE

LAST NAME:_____ FIRST NAME: _____M.I._____

S.S.#: _____ DATE OF BIRTH_____MM/DD/YY)

DEPARTMENT NAME:_____

VACCINES GIVEN:	LOT NUMBER:	PERSON GIVING VACCINE:
#1 - _____	_____	_____
#2 - _____	_____	_____

ACCEPTANCE STATEMENT

I, _____, have read the statement about varicella and the varicella virus vaccine. I have had an opportunity to ask questions and understand the benefits and risks of the vaccination. I understand that I must have two does of the vaccine. However, as with all medical treatment, there is no guarantee that I will become immune or that I will not experience an adverse side effect from the vaccine. I request that it be given to me.

_____ _____

Signature of person receiving vaccine **Date**