



Immunization History

Name _____

To Parents:

The New York State Department of Health requires a complete immunization history for each student enrolled in the EYF program. Only your student’s doctor or school nurse may complete this form and the doctor or nurse must sign at the bottom to verify that all of the information is correct. **The student cannot be enrolled until we have this information on file.**

Please return this immunization history form as soon as possible.

We also ask that you please notify the EYF program coordinator if your student has been exposed to any communicable diseases in the three weeks prior to the start of the program.

To Doctor or Nurse Practitioner:

Please complete the following information to allow your patient to be considered for the summer Explore Your Future Program at Rochester Institute of Technology.

Patient Name _____

Address _____

Date of Birth (mo/day/yr) _____ Male Female (Please check one)

DPT (Diphtheria, Pertussis, & Tetanus) List dates received	1 st	2 nd	3 rd	Booster	Booster
Polio (Oral) List dates received	1 st	2 nd	3 rd	Booster	Booster
Measles * (red/hard)	Date	Rubella * (German)	Date	Mumps *	Date 1
					Date 2
HIB (Hemophilus Influenza Type B) List dates received	1 st	2 nd	3 rd	Booster	
HB (Hepatitis B) List dates received	1 st	2 nd	3 rd	Tuberculin Test Given? Yes No	Date

* MMR (Measles, mumps, rubella) triple vaccine is usually given together.

I verify that all immunizations are current for the above named student.

Name of Doctor or Nurse Practitioner: _____

Doctor’s Address: _____

Phone Number: _____

Signature: _____ Date: _____