



# Immunization History

Student Name \_\_\_\_\_

**To Parents:**

The New York State Department of Health requires a complete immunization history for each student enrolled in the TechGirlz 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 TechGirlz 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 School Nurse:**

Please complete the following information to allow your patient to be considered for the summer TechGirlz 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 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	Booster	Booster
Polio (Oral) List dates received	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	Booster	Booster
Measles * (red/hard)	Date	Rubella * (German)	Date	Mumps *	Date
HIB (Hemophilus Influenza Type B) List dates received	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	Booster	
HB (Hepatitis B) List dates received	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	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.

Physician or school nurse's name (please print) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_