MarymountManhattan

REQUEST FOR IMMUNIZATION RECORDS

Name (Last, First, and Middle Initial): ____

Date of Birth: ____________________ Student ID Number: ____________________________

Permanent Address: ____

Phone: __________________________ E-Mail: ____

Semester I started at MMC (*e.g. Fall 2012*) : ____

I am a current MMC ☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior

I am not a current MMC Student, my last semester was ________________________________

Please check one of the following options:

☐ I will pick up the copy at the Counseling and Wellness Center, Suite 806 (Main Building-8th Floor)

☐ Please email the copy of my confidential immunization records to me:

E-mail: ______________________________

☐ Please mail the copy of my confidential immunization records to:

Name: ____

Institution/Organization: ____

Address: ____

☐ Please fax the copy of my confidential immunization records to:

Name: ____

Institution/Organization: ____

Fax Number: ____

I hereby authorize Marymount Manhattan College to release this information as indicated.

Date: ___________________________ Signature: _________________________________

Marymount Manhattan College, Counseling and Wellness Center
221 East 71st Street, New York, NY 10021
Telephone: 2 1 2 . 7 7 4 . 0 7 0 0 Fax: 2 1 2 . 7 7 4 . 0 7 1 8