MOUNT PLEASANT CENTRAL SCHOOL DISTRICT

825 WESTLAKE DRIVE
THORNWOOD, NY 10594
Tel: (914) 769-5500

IMMUNIZATIONS RECORDS RELEASE REQUEST

Today's Date: _________________

Birthdate: ______/______/_____ Daytime Phone: _____________

Year of Graduation: __________

Student's Name: ____

Current Address: ____

Mt. Pleasant Home Address:____

I, ______________________________, hereby authorize and request a copy of my Immunization Records from the Mt. Pleasant Central School District. I certify that I am 18 years or older.

Student Signature: ___________________________________

________I will pick up ______Please mail to me

- Name and address must be provided or records will NOT be released

- A government-issued photo ID must be presented or records will NOT be released.

Office Use: Form of ID Provided _______________________

*Staff member initials:*_________