



**Health Services
115 South Street
Middletown, NY 10940
(845) 341-4870**

REQUEST FOR IMMUNIZATION & HEALTH RECORDS

Date: _____

I authorize SUNY Orange Health Services to fax or mail a copy of my medical and immunization records to:

Name of School: _____ Attn: _____

Address: _____

Phone number: _____ Fax number: _____

Student: _____ DOB: _____
PLEASE PRINT NAME

Date graduated or left school: _____ "A" Number: _____

Phone: _____

Name used when student attended school if different from above: _____

Signature of student requesting records

Date

For SUNY Orange Office use only

ID Checked _____ By _____

Date Records Sent _____