Immunization Record Request Form

All immunization requests must be made in writing. ***Limit 1 request per form***. No requests will be processed without all information below properly indicated. All requests must bear the signature of the student. Please submit this form to the Registrar.

Name: _____
Last Name (While Enrolled) First Name Middle Initial

Social Security Number: _____ Date of Birth:_____

Current Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email Address: _____

Program:_____ Graduation Date: _____

Please allow 7 to 10 business days to process your request for immunization records. All immunization record requests must be picked up at the Dallas Nursing Institute campus by the student.

I give Dallas Nursing Institute permission to release my immunization records as requested above.

Student Name (please print):_____

Student Signature: _____ Date: _____

This immunization request form may be mailed or faxed to:

Dallas Nursing Institute
12170 North Abrams, Suite 200
Dallas, TX 75243
Fax: 214.575.9090 or registrar@dni.edu