Fulton City School District

PARENT/GUARDIAN STATEMENT

Student's Name _____ DOB_____

I understand that proof of New York State required immunizations for polio, mumps, diphtheria,

hepatitis and rubella from a physician or clinic is required for admission to school. Failure to file either proof of immunizations or exemptions will result in the exclusion of the pupil until such time as an appropriate immunization statement is submitted.

Permission is hereby granted to Fulton City School District to obtain all health records from my physician and scholastic records from previously attended school(s) as well as transfer records to a new school in the event of a move to another district or state.

I certify that the information provided is accurate to the best of my knowledge and that I have legal custody of the above named child.

Parent/Guardian Signature _____ Date _____

Doctor's Name _____ Phone Number _____