CALVIN COLLEGE
IMMUNIZATION RECORD REQUEST FORM

REQUEST FOR IMMUNIZATION RECORDS POLICY: There is no charge for each copy of immunization records. Requests will be completed within 2-3 business days of receipt. The student/alumni’s signature is required for each request.

REQUESTOR’S INFORMATION

Last Name  First Name  Middle Name  Former Name

Address  City  State  Zip Code

Date of Birth:  Month  Day  Year  Gender:  □ Male  □ Female

Calvin ID#:  Contact Number:  (   )  -

First Semester Enrolled:  Last Semester Attended:  Graduation Date (if applicable):

Due to privacy reasons, we are unable to email records.

Check all that apply:

_____ I will pick up a copy of my immunization records. Please call me when they are ready.

_____ Please mail a copy of my immunization records to my address listed above.

_____ Please forward a copy of my immunization records to:

<table>
<thead>
<tr>
<th>Institution/Organization Name</th>
<th>Attention</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

_____ Please fax a copy of my immunization records to:

<table>
<thead>
<tr>
<th>Name</th>
<th>Fax Number</th>
</tr>
</thead>
</table>

X ____________________________  ____________________________

STUDENT/AUTHORIZED SIGNATURE  DATE

NOT VALID WITHOUT SIGNATURE

NOTE: You may fax this completed form to (616) 526-6548 or email to health@calvin.edu for processing.

FOR OFFICE USE ONLY:

AUTHORIZED SIGNATURE VERIFIED BY/FORM RECEIVED BY (HEALTH SERVICES STAFF INITIALS): ____________

REQUEST PROCESSED:  □ PICK UP  □ MAIL  □ FAX

NOTES:  ____________________________________________  ____________________________________________

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