CALVIN UNIVERSITY

IMMUNIZATION RECORD REQUEST FORM

REQUEST FOR IMMUNIZATION RECORDS POLICY: *There is a charge for personal copies of your medical records. For questions about our fees, please call us at 616-526-6187. 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, at the above number, when ready.

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

_____ Please forward a copy of my immunization records to:

Institution/Organization Name	Attention	Address	City	State	Zip Code

_____ Please fax a copy of my immunization records to:

Name	Fax Number

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: