# *CALVIN UNIVERSITY*

# *IMMUNIZATION RECORD REQUEST FORM*

***REQUEST FOR IMMUNIZATION RECORDS POLICY:*** *There is no charge for copies of your immunization records. Requests will be completed within 3-5 business days of receipt. The requestor'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) 469-1398 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:**