PLEASE SEND TO YOUR HIGH SCHOOL OR FORMER COLLEGE/UNIVERSITY

LEWIS UNIVERSITY
A Catholic and Lasallian University

The Center for Health and Counseling Services
Mother Teresa Hall
(815) 836-5455

To:
Name of Institution: _____
Phone: _____
Fax: _____

REQUEST FOR RELEASE OF IMMUNIZATION RECORDS

Please send a copy of my immunization records to:

Lewis University
Center for Health and Counseling Services
One University Parkway, Unit #273
Romeoville, IL 60446
Fax: 815-836-5047

Student Information
(Please Print)

NAME: _____ _____ _____
*(last) (first) (middle)
**Be sure to Include maiden name, here and on copy of record, if applicable*

STUDENT ID OR SSN NUMBER: _____

DATE OF BIRTH: _____

DATES ATTENDED THE HIGH SCHOOL/COLLEGE: _____

If there is a problem or question regarding this request, please contact me at:

_____
(Student's address)

_____
(city) (state) (zip)

_____
(phone number)

_____ _____
Student's Signature Date

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