

High School or Former College/University Request for the **Release of Immunization Records Form**



A Catholic and Lasallian University

The Center for Health and Counseling Services
Mother Teresa Hall
Phone (815) 836-5455
Fax (815) 836-5047

Please send this form to your former school:

Name of Institution: _____

Phone: _____

Fax: _____

REQUEST FOR RELEASE OF IMMUNIZATION RECORDS FROM FORMER SCHOOL(S) TO LEWIS UNIVERSITY

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
Healthservices@lewisu.edu

Student Information - Please Print

NAME: _____ (last) _____ (first) _____ (middle)

**Be sure to Include maiden name, here and on copy of record, if applicable*

Lewis 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