HUSSON UNIVERSITY STUDENT HEALTH SERVICES

Release of Vaccine Records Request Form

In order to receive copies of your immunization records please complete this form and fax to 207.941.7866.

Please allow 7 business days to fulfill this request.

Your Information:

Last Name: _____ First Name: _____

Date of Birth: ____/____/____ Student ID# _____

Campus: _____ Last Date of Attendance: _____

Telephone #: (_____)_____-_____ Email: _____

Address: _____ City: _____ State: ____ Zip: _____

Please check all that apply:

- □ I will pick up my records in person.
- □ Please mail a copy of my immunization records to my address listed above.
- □ Please fax a copy of my immunization records to: _____.
- □ Please forward a copy of my immunization records to:

  Attn: _____

  _____

  _____

  _____

Student Signature: _____ Date: _____

Please note: this form is not valid without a signature and date.

Office Use Only:

Request Received _____ | Request Sent_____ | Initials_____