BOSTON COLLEGE HEALTH SERVICES

CUSHING HALL, ROOM 117, CHESTNUT HILL, MA 02467

TELEPHONE: 617 552-3216 FAX: 617 552-1671

Please print clearly and fill in this form completely so that we can quickly process your request. Due to the large volume, expect your request to be mailed within 7 – 10 days. Please make your own personal copy for your records, as we can only process one request per student per year.

IMMUNIZATION REQUEST

I authorize Boston College Health Services to release my immunization information to myself at the address below.

Signature_____ Date:_____

Please print clearly:

_____ _____ _____ _____

Last Name First Name Middle Initial Maiden Name BCC

BC ID#_____ Date of Birth:_____

Address_____ _____ _____ _____

Street Town State Zip

If we need additional information, list contact numbers below:

Tel#:(___) _____ Fax #: (___)_____

Which school(s) did you attend?

Undergraduate _____ College of Advancing Studies_____

Graduate – Masters_____ Graduate – Doctorate_____

What year did you begin your studies?_____ What year did you graduate?_____

Did you transfer in to BC? Yes or No Evening/Transfer student: when did you start?_____

Did you complete your degree program? Yes or No

****

Below is for BC Use only

****

Date received:_____ Date sent:_____ Initial:_____ Mailed:____Fax:____ Pickup:_____

6/2004