**BOSTON COLLEGE HEALTH SERVICES**
**140 COMMONWEALTH AVE, CHESTNUT HILL, MA 02467**
**TELEPHONE: 617-552-3225 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 of requests, please allow **7-10 business days** for the request to be mailed. Please make your own personal copies for your records, as we can only process one request per student.

## 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

BC ID#_____ Date of Birth:_____

Address_____ _____ _____ _____
Street City State Zip

If we need additional information, please 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

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Below is for BC Use only

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