



Immunization and Medical Record Request Form

Name: _____

Phone: _____

W# or SS#: _____

Date of Birth: _____

1st Semester at Southeastern (ex. Spring 06): _____

Have you ever been a patient at the Health Center? Circle one: Y N

I am requesting (check all that apply):

_____ **Entire Health Record**

_____ **Immunization Records**

_____ **Other** _____

I would like my records (circle one) faxed / mailed / released to

(school, business or person's name)

The fax number is: _____

OR

The mailing address is: _____ (street and number)

_____ (city, state, and zip)

Signature and date: _____

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