

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

Below is for BC Use only

Date received: _____ Date sent: _____ Initial: _____ Mailed: _____ Fax: _____ Pickup: _____