WCSU HEALTH SERVICES

181 White Street
Danbury, CT 06810
Phone: (203) 837-8594 Fax: (203) 837-8583

Consent for Release of Immunization Records

Name (Please print): ____

Date of Birth: ___________________ Student ID: _________________

Phone: ___________________________

I authorize the release of my immunization records as indicated below.

Signature: _______________________________ Date: ________________

Please select one of the choices below to indicate how you would like to receive your immunization record:

- ❑ ***Pick up at Health Service***
- ❑ ***mail to your home***

Address: ____
____
____

- ❑ **mail or fax to a designated college or university**

University: ____
Address: ____
____
____
FAX: ____

For Health Service use only

Date Completed: ________________________ Initials: ___________