Student Health Center
Request for Release of Immunization Information

Date of request ______________________________

Name of Person Needing Information ______________________________

Birth date ______________________________

Telephone number ______________________________

Year(s) at William Jewell College ______________________________
5 years-- legal limit to retain information

Graduate ______________ Transfer Student ______________

Other Activities at WJC that required Immunization Information

Athletic Department ____________________
Overseas Travel ____________________
Nursing Department ____________________

Name of Person or Institution to Mail ______________________________

Mailing Address (required)

____
Street Address

____
City State Zip Code

Fax Number (_____) ________________________

Attention to ______________________________

Search date _______________ Sent date ___________________

Unable to locate_______________ Notification date___________________