IMMUNIZATION REQUEST FORM

Winthrop University Health Center
217 Crawford Building
Rock Hill, SC 29733
Phone: (803)323-2206 ~ Fax: (803)323-3332 ~ Email:
wuhealth@winthrop.edu

HEALTH RECORD RETENTION POLICY:
Immunization records are kept on file by the University for a period of ten (10) years.

REQUEST FOR IMMUNIZATION RECORDS POLICY: This form must be completed in order to process your request. Please allow up to two weeks to process.

FOR OFFICE USE ONLY: DATE RECEIVED: _____ DATE COMPLETED: _____

Immunization Records Request Form
Please print clearly: (include full name, address) Winthrop ID#: (if available) _____

Last Name: _____ First Name: _____ M.I. _____

Date of Birth _____/_____/_____ Maiden/Other Name(s): _____

Address: _____

E-mail address: _____

Phone: _____ Fax: _____

Are you a current student? _____ If so, what year did you enroll? _____

Inactive student, please answer the following:
First Semester Enrolled: _____ Date last attended: _____ Fall, Spring, or Summer

Please keep a copy for your personal file before you release them to another organization.

Check how you would like to receive your records. **Note:** the Health Center does not email records.

____ I will pick up a copy of my immunization records.

____ Please e-mail to _____

____ Fax to _____

____ Please mail to the following address _____

I, the above named student, authorize the Winthrop University Health Center professional/clinical staff to release my immunization records.

Signature: _____ Date: _____

Received by: _____ Date: _____

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