

ROOSEVELT UNIVERSITY

Enrollment Services, 430 S. Michigan Ave., Chicago, IL 60605, Rm 854, (312) 341-3540 fax: (312) 341-3539

Immunization Release Form

STUDENT ID# or SS#: _____	Date of Birth: _____	Date: _____
NAME: (Print) _____	FORMER NAME: _____	
ADDRESS: _____		
Street	City	State Zip
Hm. Ph: (____) _____	Wk. Ph: (____) _____	
First Semester Enrolled: _____	Email: _____	

PLEASE SEND IMMUNIZATION RECORD TO:

_____ **ME at the above address.**

_____ **AND/OR the institution listed. Print complete address below:**

Institution:		
Department:	Attn:	
Address:		
City:	State:	Zip:

I authorize Roosevelt University to release my Immunization Record as indicated above.

STUDENT'S SIGNATURE: _____

Office Use only:

- Record sent** _____
- Record never submitted by the student**