IMMUNIZATION RECORD request from Lincoln College

Name_____ Date Requested_____

Home Address_____

City_____ State_____ Zip_____

Phone (to contact with questions)(home or cell)_____

I request that a copy of my immunization record be sent to:

Name_____

Street Address_____

City_____ State_____ Zip_____

FAX Number_____

Student Signature _____

Lincoln College Student ID Number _____

Date of Birth _____

Year of FIRST semester at Lincoln College _____

PLEASE COMPLETE, SIGN, AND RETURN TO:

Diane Stephenson R.N. B.S.N.
Director of Health Services
Lincoln College
300 Keokuk Street
Lincoln, IL 62656
Office: 217-735-7340
FAX: 217-735-5214