Office of Health Services

RELEASE OF INFORMATION

TO WHOM IT MAY CONCERN:

I, _____, request that a copy
(Print Name)
of my Health Record (specifically my immunization record) be sent to:

HEALTH SERVICE
LINCOLN COLLEGE
300 KEOKUK STREET
LINCOLN, ILLINOIS 62656
OR
FAX: 217/735-5214,
Attn: Diane Stephenson R.N. B.S.N.

This information is required for my admission to Lincoln College.

Signature _____

Date _____

Birth Date _____

Social Security Number _____

Year Graduated/Attended _____

Name of High School /College Attended _____

City & State of school _____