

Request for Medical Information

Complete and return this form to the address below.

Date: _____ **Student ID Number or SS#** _____

Last Name	First Name	Middle Initial	Maiden Name
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Please List **All Last Names** that you may have used on records: _____

Street Address	City	State	Zip
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Home Phone	Cell Phone	Work Phone	E-mail Address
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Is this Street Address New: Yes No Birth Date: _____

Did your Graduate from St. Elizabeth: YES NO If YES, Month and Year: _____

If NO, Dates of Attendance _____ to _____

I request [1] the following medical information [2] be sent to the person, at the address below:

1. Information from your health file that you wish to be sent:

- | | | |
|---|---|---|
| <input type="checkbox"/> Self-report of medical history | <input type="checkbox"/> Physician's exam report | <input type="checkbox"/> Chem Profile results |
| <input type="checkbox"/> Immunization records | <input type="checkbox"/> CBC results | <input type="checkbox"/> Varicella Titer |
| <input type="checkbox"/> Rubella titer | <input type="checkbox"/> Hepatitis B Antibody titer | |
| <input type="checkbox"/> Other, please specify _____ | | |

2. Because this information is confidential, it must be sent to a specific person. Please Note: because this is confidential information, the School WILL NOT FAX ANY PART OF YOUR HEALTH RECORD TO A THIRD PARTY. Please identify to whom the above information is to be sent:

Copy 1

Copy 2

Name

Name

College, Hospital or Receiving Agency

College, Hospital or Receiving Agency

Address

Address

City, State, Zip

City, State, Zip

For additional copies, please attach additional page(s) with name and address to whom copies are to be sent.

Signature

Date

Send This Request Form To:

**Health Officer
St. Elizabeth School of Nursing
1508 Tippecanoe Street
Lafayette IN 47904-2198**

<p>Office Use Only: Date Rec: _____</p> <p>Date Sent: _____ By: _____ Copy to File</p>
