UNIVERSITY OF BRIDGEPORT

Student Health Services
60 Lafayette Street, Room 119
Bridgeport, CT 06604

tel (203)576-4712
fax (203) 576-4715
healthservices@bridgeport.edu

In order to receive copies of your immunization records please complete this form and fax to (203)576-4715.

Release of Vaccine Records

Name: (Last)_____ (First)_____

Date of Birth: ____/____/____ Student ID# ____ ____ ____ ____ ____ ____

Contact Telephone # (_____)_____-_____

Email: _____@_____

I authorize the University of Bridgeport Student Health Services to release my vaccine records to the following:

_____

Name Business

☐ Fax _____

☐ Mailing Address _____

This information cannot be emailed.

Student Signature: _____

Date

Please Allow 5 business days to fulfill this request.

Office Use Only:
Request Received _____

Request Sent_____ Initials_____