University of Saskatchewan

Immunization Requirements Consent

I agree to comply with all immunization requirements of the University of Saskatchewan. I give consent for my immunization records and/or serology results to be shared with my College, clinical placements and administrative staff, as appropriate.

Student Signature: _____

Name (*please print*): _____

Date: _____

College of: __ Dentistry __ Medicine __Nursing __ Pharmacy & Nutrition _Physical Therapy __ WCVM

Graduating Year: _____

Student Information

Last Name: _____ Given Name(s): _____

U of S Student Number: _____ DOB (dd/mm/yr): _____ M/F

Health Card Number: _____ Province: _____ Expiry Date: _____

Saskatoon Address/Postal Code: _____

Telephone: (C) _____ (H) _____

U of S NSID: _____

Emergency Contact (Name/Phone/Address): _____

_____