

## 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 Information

Last Name: \_\_\_\_\_ Given Name: \_\_\_\_\_  
 DOB (dd/mm/yr): \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Health Card Number: \_\_\_\_\_ Province: \_\_\_\_\_ Exp: \_\_\_\_\_ M/F  
 Saskatoon Address & Postal Code: \_\_\_\_\_  
 Next of Kin (name/phone #/relation): \_\_\_\_\_  
 U of S Student Number: \_\_\_\_\_  
 USASK NSID & Email: \_\_\_\_\_  
 Previous visit to Student Wellness Centre: \_\_\_\_ Yes \_\_\_\_ No

<i>College</i>	<i>Saskatoon Campus</i>	<i>Regina Campus</i>	<i>Prince Albert Campus</i>	<i>OTHER</i>
Dentistry				
Dental Assisting				
Dental Therapy				
Nutrition				
Pharmacy				
Masters of Public Health				
Physical Therapy				
Veterinary Medicine				
Medicine				
Nursing				
Nursing Post Degree				
Nurse Practitioner				

Graduating Year: \_\_\_\_\_

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_