

## 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>
Dentistry		
Dental Assisting		
Nutrition		
Pharmacy		
Masters of Public Health		
Physical Therapy		
Veterinary Medicine		
Medicine		
Nursing		
Nursing Post Degree		
Nurse Practitioner		

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

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