

HEALTH INFORMATION REQUEST FORM

Name _____ Date Requested _____

Home Address _____

City _____ State _____ Zip _____ Presently Enrolled at LC? Y N

Date of Birth _____ LC ID Number _____

I request that the following health records:

Immunization (shot) record _____ Physical _____ Other _____

Please send to the following:

Name _____

Street Address _____

City _____ State _____ Zip Code _____

OR FAX number _____

Student Signature _____

PLEASE COMPLETE, SIGN, AND RETURN TO:

**Health Service
Lincoln College
300 Keokuk Street
Lincoln, IL 62656**

FAX: 217/735-5214

QUESTIONS? 217-735-5050, ext. 340