

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: _____