

## Confirmation of Complete Immunization Records

Student Name \_\_\_\_\_

School \_\_\_\_\_

As the affiliated program, \_\_\_\_\_

Verifies that \_\_\_\_\_ has all

immunizations up to date, complete and on file at the institution. This agree-

ment that these health files comply with the standards set by Fairfield

Medical Center and its accrediting body. Fairfield Medical Center honors the

partnerships and maintains the integrity with all programs and students who

Use the Fairfield Medical Center facility.

\*\* This agreement also validates and gives Fairfield Medical Center the right to perform random audits with student immunization files.

Signature and Title \_\_\_\_\_

Date \_\_\_\_\_