IMMUNIZATION RECORD REQUEST FORM

Name on Immunization Record

Last Name: __________________________  First Name: _____________________________

Date of Birth: ___/___/_______  Address:_____________________________________________

City: ________________  State: ______________  Zip: ______________________

Print name of person requesting the record (Must be self, parent, or legal guardian)
__________________________________________________________________________________

Phone: __________________________

Signature: ______________________  Date Requested: ___/___/_______

I would like to:  pick up record  Have it mailed to me  fax to: _______________________________

Please allow _______________________________ to pick up my records.

PLEASE ALLOW 7 – 10 BUSINESS DAYS FOR YOUR IMMUNIZATION RECORD TO BE AVAILABLE. PLEASE ALSO NOTE – DUE TO THE HIGH VOLUME OF REQUESTS, WE ADVISE YOU TO CALL BEFORE COMING TO PICK UP YOUR RECORDS. THANK YOU.

To be completed at time of pick up:
Please print the name of the person picking up the records: ______________________________

Signature: ______________________  Date: ___/___/_______

8/2018

*This agency is an equal provider of services and an equal employment opportunity employer – Civil Rights Act 1964 (CRA)