

IMMUNIZATION RECORD REQUEST FORM

Name on Immunization Record _____

Last Name _____ First Name _____

Date of Birth ____ / ____ / ____ Address _____

City _____ State _____ Zip _____

Name of person requesting record (PRINT) _____

Phone: _____ (Must be self, parent, or legal guardian)

Signature _____ Date: _____

I would like to (Circle one)

Pick up record Have it mailed to me please fax to: _____

Please allow _____ to pick up my records

PLEASE ALLOW 7-10 BUSINESS DAYS FOR YOUR IMMUNIZATION RECORD TO BE AVAILABLE – *Please note, due to the high volume of requests, please call before coming to pick up your records. Thank you*

To be completed at the time of pickup:
Please print the name of the person picking up the records _____
Signature _____ Date: _____