First District Health Unit
Immunization Record Request Instructions

Please complete this form by clearly printing all information and attaching or bringing any additional supporting documentation required.

- Need a photo ID when requesting an immunization record for verification.
- If the record requested is for a person younger than 18, please state your relationship to the child. If applicable please provide documentation of custody or guardianship.
- 18 and older need to make their own request.

There is a $10.00 charge for record requests from clients that have not received immunizations here.

Immunization Record Request				
Requested Method for Record to be Sent: ☐ Mail ☐ Fax ☐ Email ☐ Pick-Up				
Requested Immunization Record Information				
Last Name:	First Name:	Date of Birth:		
Last Name:	First Name:	Date of Birth:		
Last Name:	First Name:	Date of Birth:		
Requestor's Information				
Requestor's Last Name:	Requestor's First Name:			
Relationship: ☐ Self ☐ Parent ☐ Guardian / Foster Parent				
Street Address:				
City:	State:	ZIP Code:		
Telephone Number:	Fax Number:			
Email Address (if requested to be sent via email):				
Verification of Supporting Documentation: ☐ Photo ID ☐ Court Order Granting Guardianship ☐ Verbal Consent from Social Services				
Requestor's Signature:				
First District Health Unit (For Office Use Only)				
Date Received:	Date Fulfilled:	Initials:	Amt collected:	Cash / Credit Card / Check

1/17/2020