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

2/3/2025