Public Health
Prevent. Promote. Protect.

Butler County
Health Department

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)

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