Public Health
Prevent. Promote. Protect.

Butler County
General Health District

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: ___/___/_____

*This agency is an equal provider of services and an equal employment opportunity employer – Civil Rights Act 1964 (CRA)
Revised 8/2018