



## Request for Immunization/Vaccination Record

DATE: \_\_\_\_\_

FIRST NAME: \_\_\_\_\_ MIDDLE NAME \_\_\_\_\_ LAST NAME: \_\_\_\_\_  
(printed)

PATIENT NAME (signature): \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

GUARDIAN NAME if person is under  
the age of 18 years (printed): \_\_\_\_\_

GUARDIAN NAME if person is under  
the age of 18 years (signature): \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

CONTACT PHONE NUMBER: ( \_\_\_\_\_ ) \_\_\_\_\_

I request a copy of the immunization/vaccination record for the person listed below.

- I understand in the interest of maintaining the confidentiality of the record, this request must be notarized by a notary public if this form is mailed to the address listed below.
- If this form is handed to my current health care provider, the notarization is not required.

Mailing Address: New Hampshire Department of Health and Human Services  
Division of Public Health Services  
Bureau of Infectious Disease Control, Immunization Program  
29 Hazen Drive  
Concord, NH 03301  
attn.: Registry Administrator

Patient (Parent) Signature: \_\_\_\_\_

Subscribed and sworn before me this \_\_\_\_\_ Day of \_\_\_\_\_ (Month), \_\_\_\_\_ (Year)

Notary's Signature and Seal

Date My Commission Expires: \_\_\_\_\_