



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 03224
attn.: Registry Administrator

Patient Signature: _____

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

Notary's Signature and Seal

Date My Commission Expires: _____