



Community Health Nursing

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Aixsa Pérez, MD
Health Officer

REQUEST FOR INFORMATION

I request that the immunization/travel record(s) of my child or myself be released to me or the individual I designate.

Child/clients name(s)

Birthday

Send the record to the following address:

Name

Street Address

City State Zip

Telephone # (if no address)

We will send or fax the record to your physician or the child's school if you would prefer.

Name

Street Address

City State Zip

Telephone # (if no address)

Fax #

Please Note: Your request will be honored as soon as possible, please allow 3 working days and an additional 2-3 days for the mail from the date of the request.

Signature _____ **Date** _____

Relationship to child/client _____

This has been explained to me in my own language

Staff: Information request completed by _____ **Date** _____

Letter sent by _____ **Date** _____