REQUEST FOR IMMUNIZATION RECORDS

1. Please provide the following information:

   **Patient’s Name:** ____________________________________________

   **Previous Name(s):** ____________________________________________  
   (if applicable)

   **Current Address:** ____________________________________________

   **City, State and Zip Code:** ____________________________________

   **Telephone Number:** ____________________________  
   Cell or Home (circle one)

   **Date of Birth:** ____________________________

   **Fax Number** (including area code): ____________________________  
   (where record should be faxed)

2. Attach the following information:

   Copy of patient’s driver’s license or photo ID (if 18 years of age or older)  
   **OR**
   Copy of parent or guardian’s driver’s license or photo ID

3. Sign and date below:

   ____________________________________________  
   Signature of Patient or Legal Representative  
   ____________________________  
   Date

   Print Name of Person who signed as Patient or Legal Representative above

4. Fax to the Ottawa County Health Department listed below.

   **Holland Office**  
   12251 James Street, 500  
   Holland, MI 49424  
   Phone: 616-396-5266  
   Fax: **616-393-5659**

   **Hudsonville Office**  
   3100 Port Sheldon  
   Hudsonville, MI 49426  
   Phone: 616-669-0040  
   Fax: **616-669-3039**

   **Grand Haven Office**  
   1207 S. Beechtree, B  
   Grand Haven, MI 49417  
   Phone: 616-846-8360  
   Fax: **616-844-1778**