PhilaVax

DEPARTMENT OF PUBLIC HEALTH

Immunization Record Request

Proper identification is required for record retrieval (such as a Driver's License). Attach a copy of your ID with this request.

Patient Information

Last Name	First Name	Middle Name
Date of Birth	Address	
City	State	Zip Code

Requester Information

Last Name	First Name	Middle Name
Relationship to Patient (self, mother, etc.)	Address	
City	State	Zip Code
Phone Number	Fax Number	Email
Signature		Today's Date

Fax Number: 215-238-6944

Scan and Email: PhilaVax@phila.gov

Mail: PhilaVax
1101 Market St., 12th Fl.
Philadelphia, PA 19107

For Official Use Only

Approved By: _____

Date: _____

Type of ID: _____

ID #: _____