PhilaVax

Immunization Record Request Form

Proper identification is required for record retrieval (such as a Driver's License, State ID, or Passport).

Attach a copy of your ID with this request.

☐ **Immunization Record Request** ☐ **COVID-19 Vaccine Record Request**

Patient Information

Last Name	First Name	Middle Name
Date of Birth	Address	
City	State	Zipcode

Requester Information

Last Name	First Name	Middle Name
Relationship to Patient (self, mother, etc)	Address	
City	State	Zipcode
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 #: _____