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 #: _____