



Request for Immunization Record

Section I (To Be Completed by Student)

Name \_\_\_\_\_ Student ID# \_\_\_\_\_
Date \_\_\_\_\_ Primary Phone (\_\_\_\_\_) \_\_\_\_\_

Section II (Please Read and Complete)

I hereby request a copy of my immunization record. Please select how you'd like to receive your Immunization Records (Please select one):

- Home Address: \_\_\_\_\_
Faxed to: (\_\_\_\_\_) \_\_\_\_\_
Mailed to Institution: \_\_\_\_\_
Self Pick-Up

Section III (Please Sign )

Student's Signature \_\_\_\_\_ Date \_\_\_\_\_

Section IV (Office Use Only)

Received by: \_\_\_\_\_
Date received: \_\_\_\_\_
Date and route of delivery: \_\_\_\_\_

Please bring the completed and signed form to the:

Office of Immunization Certification
OR
Mail the documents to:
Office of Immunization Certification
Southern Polytechnic State University
1100 South Marietta Pkwy
Marietta, GA 30060