Capital Health

Request for Immunization Record from Public Health

According to Capital Health policy all information contained in the health record which includes immunization information must be kept confidential but released under certain circumstances.

Children under the age of 16 - A parent is able to make a written request using this form for immunization records for children under the age of 16. A signed release of information is **not required from the child.**

Children ages 16 and over - If a parent requests immunization records and their child is 16 years of age or over, the child must sign a release of information giving permission to release those records.

In Capital Health, childhood and adult immunizations are given by family physicians and school immunizations are given by Public Health nurses. Your family physician may also have your immunization records. If you attended school in another part of Nova Scotia, you will need to contact the Public Health Office in that area to request your school immunization records.

1. CLIENT IDENTIFICATION INFORMATION (please print clearly)

Last Name _____ First Name _____ Middle Initial _____

Full Mailing Address (include postal code) _____

_____
(town / city) (postal code)

Previous Surname _____ Date of Birth _____ / _____ / _____
Year Month Day

Nova Scotia Health Card Number _____

Daytime telephone number _____ _____
Area code Telephone Number

2. SCHOOL INFORMATION – Schools attended in Capital District (if applicable)

Elementary School(s) _____ Year(s) _____

Junior High School(s) _____ Year(s) _____

High School(s) _____ Year(s) _____

3. I AUTHORIZE THE RELEASE OF MY IMMUNIZATION INFORMATION TO THE FOLLOWING PERSON(S):

_____
(Name of Person or Organization to receive information)

_____
(Address) (City)

_____
(Province / State) (Postal / Zip Code)

_____ _____
(Area Code) (Telephone Number) (Area Code) (Fax Number)

4. SIGNATURE (required for all requests)

I give permission to Public Health (Capital Health) to release copies of my Immunization Record to myself or the person / organization named in Section 3.

Client signature _____ Date _____

Guardian / Legal next-of-kin _____ Date _____

Relationship to the client _____

5. SENDING INFORMATION

How do you want Public Health to send your Immunization Record (please check one):

__ Fax – _____ _____ _____
(Area code) (fax number) (person receiving the fax)

__ Mail – ensure your mailing address in section one is complete and legible.

__ Pick up at office – phone number to contact you when record is ready for pick-up _____

FAX OR MAIL THIS COMPLETED FORM TO:

Main Office:
Public Health Services
Immunization Records
7 Mellor Ave Unit 5
Dartmouth, NS B3B 0E8
Tel: 902-481-5890
Fax: 902- 481-8928
www.cdha.nshealth.ca

Windsor Office:
Public Health Services
P O Box 908
80 Water Street
Windsor, NS B0N 2T0
Tel: (902-798-2264
Fax: 902-798-5922

Musquodoboit Harbour Office:
Public Health Services
7907 Highway 7
Musquodoboit Harbour, NS B0J 2L0
Tel: 902- 889-2143
Fax: 902-889-3013

Middle Musquodoboit Office:
Public Health Services
Musquodoboit Valley Memorial Hospital
492 Archibald Brook Road
Middle Musquodoboit, NS B0N 1X0
Tel: 902-384-2370
Fax: 902-384-2029

Office Use Only:
Date Received: _____ In ANDS: __ Yes __ No

Date Request Completed: _____