Fax Permission Acknowledgement

Child Immunizations Records

_____, health agency, respectfully request the
Print health agency name please

Immunization records for: _____
Print child's name please

Date of birth: _____ Child's DCN#_____

Signed _____ Date _____

Print name_____

Kansas City Health Department
2400 Troost
Kansas City, Missouri 64108
Fax (816) 513-6288

IMMEDIATE ACTION REQUESTED
Monday-Friday 8:30 – 4:00

Your fax number: _____
Please write legibly