

ARLINGTON HIGH SCHOOL & FOREST VIEW HIGH SCHOOL
ALUMNI IMMUNIZATION REQUEST FORM



♦ A photocopy of your current Driver's License or State Identification must be submitted with this form ♦

Number of copies requested ☐ \$10.00 each

Print current information

Name _____ Maiden _____ Graduation Year _____
Address _____ Date of Birth _____
City, State, Zip _____ Phone _____
Signature of Alumni (**not** parent) _____ Date _____

I give permission to mail my high school immunization record to:

Name _____
Attention _____
Address _____
City, State, Zip _____

PLEASE NOTE:

- ♦ Mail your request form (verbal, faxed or e-mail requests are not accepted).
- ♦ Only you can request/sign for your immunization record to be released.
- ♦ Requests will not be processed without a completed form that includes your **signature, payment** and a **photo ID**.

MAIL TO: High School District 214
Attention: Registrar
2121 S. Goebbert Road
Arlington Heights, IL 60005

OFFICE USE ONLY

Date Received _____ Total Fee Received _____ Date Mailed _____