ARLINGTON HIGH SCHOOL & FOREST VIEW HIGH SCHOOL

ALUMNI IMMUNIZATION REQUEST FORM

214 HIGH SCHOOL DISTRICT

✦ 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

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OFFICE USE ONLY

Date Received _____ Total Fee Received _____ Date Mailed _____