

Request for Immunization Record

Please Print Clearly

MAKE CHECK OR MONEY ORDER TO SAMHD FOR \$5.00 EACH COPY
SEND A SELF ADDRESSED STAMPED ENVELOPE TO ADDRESS LISTED:
SAMHD, 332 W. COMMERCE RM 108, SAN ANTONIO, TX 78205

Client's Information

Last: _____ First: _____ Middle: _____

Sex: Male Female

Date of Birth:

//

Medicaid Number (if applicable):

Name of Last Health Care Provider or Clinic If Known

Mother's Maiden Name (name before marriage)

Last: _____ First: _____

Mother's Date of Birth:

//

Applicant Information

Relationship to Client: Mother Father Guardian Other _____
(please describe, e.g. grandparent)

Last Name

First Name

Street Address

Apt#

City

State

Zip Code

PHONE --

This is to certify that I am the parent, guardian, custodian, or other such person in parental relationship to the client listed above, or the individual to whom the record relates. I understand that all information submitted to San Antonio Immunization Registry System (SAIRS) will be kept confidential.

Signature of Applicant

Date