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

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OFFICE USE ONLY

Date Received _______________       Total Fee Received __________       Date Mailed _______________

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