



# Request Copy of California Immunization Record



The San Diego Regional Immunization Registry (SDIR), part of the California Immunization Registry (CAIR), is a public health program that creates a computer record of your or your child's vaccines. This electronic record helps you and your doctor track the shots you or your child receives and reminds you when new shots are needed for protection against serious illnesses. The information in the registry is confidential and is not released to any unauthorized person or group.

You have the right to request a copy of your or your child's immunization record with the proper/valid identification. For more information, please call **SDIR** at (619) 692-5656. You can fax this completed form and a copy of your photo ID to fax (619) 692-6619. Mailing Address: SDIR, Immunization Branch, 3851 Rosecrans Street, Suite 704, San Diego, CA 92110.

**Please print clearly**

### PERSONAL INFORMATION

Complete as much information as possible so that we can accurately locate your/your child's immunization record.

<i>First Name</i>	<i>Middle Name</i>	<i>Last Name</i>		
		M	F	
<i>Alias / Nickname</i>	<i>Date of Birth</i>	<i>Gender</i>		
<i>Address</i>	<i>Apt. No.</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>

### PATIENT/PARENT/LEGAL GUARDIAN'S INFORMATION (if requesting a record for a child under 18 years of age)

Complete as much information as possible so that SDIR can properly identify you as the patient/ parent/legal guardian of the patient.

<i>First Name</i>	<i>Middle Name</i>	<i>Last Name</i>			
<i>Type of Identification and number</i>	<i>Date of Birth</i>	M	F	<i>Relationship to the Patient</i>	
<i>Address</i>	<i>Apt. No.</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>	<i>Telephone</i>

\_\_\_\_\_ **I requested/received a copy of my child's immunization record and provided a proper identification to SDIR. (Please Initial)**

\_\_\_\_\_ **I requested/received a copy of my immunization record and provided a proper identification to SDIR. (Please Initial)**

\_\_\_\_\_  
*Signature of patient/parent/legal guardian* \_\_\_\_\_ *Date*

\_\_\_\_\_  
*Verified by (Registry staff)*      Verified on \_\_\_/\_\_\_/\_\_\_