



REQUEST FOR HIGH SCHOOL IMMUNIZATIONS RECORDS

Attn: Missy Tingley, RN

I am authorizing the release of my Paris High School Immunization Records.

Name (AT GRADUATION): _____

Date of Birth: _____

Year of Graduation: _____ OR Year of Withdrawal: _____

Please release my immunization records to:

- Fax: _____
- Email: _____
- Address: _____

Please provide a phone number where you can be reached in the event of questions regarding your records. _____

Signature: _____

Date: _____