

To: [Name of Pediatrician or Clinic Name]

Address: [Clinic Street Address, City, State, Zip Code]

Phone: [Clinic Phone Number]

Date: [Current Date]

RE: Request for Immunization Records for School Enrollment

Patient Name: [Child's Full Name]

Date of Birth: [Child's Date of Birth]

Dear Medical Records Department,

I am writing to request a certified copy of the immunization records (State Immunization Form) for my child, [Child's Name], for the purpose of school enrollment.

Please provide a record of all vaccinations received to date, including dates of administration and the healthcare provider's signature or clinic stamp.

Please deliver the records via the following method:

- I will pick them up in person on [Date].
- Please mail them to: [Your Home Address].
- Please fax them to the school at: [School Fax Number], Attention: [School Registrar/Nurse].
- Please email them to: [Your Email Address].

If there are any fees associated with this request or if you require a signed authorization form, please notify me immediately at [Your Phone Number].

Thank you for your prompt assistance with this matter.

Sincerely,

[Your Signature]

[Your Printed Name]

[Relationship to Patient]