

Request for Immunization Record from Public Health

Office Use Only
Date Received:
Date Completed:
PANORAMA _____ PAPER _____
ANDS _____ ANDI _____
Fax _____ Mail _____ Pick up _____

According to Nova Scotia Health Authority, Central Zone policy all information contained in the health record which includes immunization information must be kept confidential but released under certain circumstances.

Children under the age of 16

A parent is able to make a written request using this form for immunization records for children under the age of 16. A signed release of information is not required from the child.

Children ages 16 and over

If a parent requests immunization records and their child is 16 years of age or over, the child must sign a release of information giving permission to release those records.

In Nova Scotia, childhood and adult immunizations are given by family physicians and school immunizations are given by Public Health nurses. Your family physician may also have your immunization records. If you attended school in another part of Nova Scotia, you will need to contact the Public Health Office in that area to request your school immunization records.

1. CLIENT IDENTIFICATION INFORMATION (please print clearly)

Last Name _____			First Name _____			Middle Initial _____		
Full Mailing Address (include postal code) _____								
_____						_____		
(town/city)						(postal code)		
Previous Surname _____				Date of Birth _____ / _____ / _____				
				YYYY MM DD				
Nova Scotia Health Card Number _____								
Daytime telephone number _____			_____			_____		
			Area code			Telephone Number		

2. SCHOOL INFORMATION – Schools attended in Central Zone (if applicable)

Elementary School(s) _____	Year(s) _____
Junior High School(s) _____	Year(s) _____
High School(s) _____	Year(s) _____



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3. I AUTHORIZE THE RELEASE OF MY IMMUNIZATION INFORMATION TO THE FOLLOWING PERSON(S):

_____ (Name of Person or Organization to receive information)			
_____ (Address) (City)			
_____ (Province / State) (Postal / Zip Code)			
_____ (Area Code)	_____ (Telephone Number)	_____ (Area Code)	_____ (Fax Number)

4. SIGNATURE (required for all requests)

I give permission to Public Health (Nova Scotia Health Authority) to release copies of my Immunization Record to myself or the person / organization named in Section 3.	
Client signature _____	Date _____
Guardian / Legal next-of-kin signature _____	Date _____
Relationship to the client _____	

5. SENDING INFORMATION

How do you want Public Health to send your Immunization Record (please check one):		
<input type="checkbox"/> Fax – _____	(Area code) _____	(fax number) _____
(person receiving the fax) _____		
<input type="checkbox"/> Mail – ensure your mailing address in section one is complete and legible.		
<input type="checkbox"/> Pick up at office – phone number to contact you when record is ready for pick-up _____		

FAX, MAIL or EMAIL THIS COMPLETED FORM TO:

Main Office:

Public Health Services
 Immunization Records
 7 Mellor Ave, Unit 5
 Dartmouth, NS B3B 0E8
 Tel: 1-(902) 481-5890
 Fax: 1-(902)-481-5803
 immunizationrecordrequest@nshealth.ca

Website: www.nshealth.ca