Wyandot County Public Health
127- A South Sandusky Avenue
Upper Sandusky, OH 43351
Phone 419-294-3852 | Fax 419-294-6435
www.wyandothealth.com
Equal Opportunity Employer/Provider

Please note: A copy of all necessary supporting documentation, a valid phone number, & proper signatures must be submitted with your request, or it will not be processed

See list below for acceptable forms of documentation:

- To obtain a record for yourself, one of the following must be provided:
  - Current Driver's License, State Identification Card, or U.S. Passport
- To obtain a record for a minor, you must provide proof of your status as a parent or guardian with one of the following:
  - Birth Certificate, Legal Guardian Paperwork, Custody Paperwork or most recent Tax Return showing the child listed as a dependent. **AND**
  - You must also provide identification for yourself, by providing a copy of one of the following: Driver's License, State Identification Card, U.S. Passport.
- To obtain a record for someone you are a guardian of (child or adult), you must provide a copy of:
  - Custody paperwork, legal guardian paperwork, or healthcare power of attorney.

You may return the form by mail, email, fax, or in-person

By Mail/In- Person:
127-A S. Sandusky Ave.
Upper Sandusky, Ohio, 43351

By Email:
nursing@co.wyandot.oh.us

By Fax:
419-294-6435

*Please allow 1-2 business days for your request to be processed

Wyandot County Public Health
127- A South Sandusky Avenue
Upper Sandusky, OH 43351
Phone 419-294-3852 | Fax 419-294-6435
www.wyandothealth.com
Equal Opportunity Employer/Provider

Immunization Record Request

Date of Request: _____

Patient Information:
Name (First, Last): _____ Patient Date of Birth: _____

Address: _____ City: _____ State: ____

Zip Code: _____

Person Requesting Information **(*if patient is a minor, person requesting a record must be a legal guardian):**
Name (First, Last): _____ Relation to Patient*: _____

Phone Number: _____ Reason for Request: _____

I authorize Wyandot County Public Health (WCPH) to release my immunization record to the individual or entity listed below:

Mail
Name: _____

Address: _____ City: _____ State: _____

Zip Code: _____

Fax
Fax #: _____ Attention to: _____

Email
Email: _____ Attention to: _____

Method of Delivery: ☐ **Pick-up** ☐ **Mail** ☐ **Fax*** ☐ **E-mail***

** If you select the e-mail/fax option, you hereby acknowledge and accept the inherent risk associated with an unsecured transmission, which can place your information at risk of being read or accessed by someone else, and you agree that Wyandot County Public Health will not be responsible for disclosures that might occur in transit.*
This facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____

(Office Use Only)

Request completed by: _____ Title: _____ Date of completion: _____
Verified ID ____ Verified guardian status ____

(Revised 3/19/2024)