

Out-of-State/Country Immunization Record Transfers

Today's Date: _____

Patient Identification:

Full Legal Name (as it appears on the birth certificate)

Last Name First Name Middle Name Suffix



Sex (Circle One): Male Female Race (Circle one): (American Indian/Alaskan) (Asian Indian) (Black/African American)
(Chinese) (Filipino) (Guamanian/Chamorro) (Hawaiian) (Japanese)
(Korean) (Other Asian) (Other Nonwhite) (Other Pacific Islander)
(Samoan) (Vietnamese) (White) (Unknown)

Date of Birth (MM/DD/YYYY): ____/____/____ Grade in School this year (if applicable): _____

Patient Information:

Physical Address: _____

City: _____ State: _____ ZIP: _____

County: _____

Mailing Address (if different): _____

City: _____ State: _____ ZIP: _____

County: _____

Language: _____ Phone: (____) ____ - _____ E-mail Address: _____

Parent/Guardian Information:

Relationship to Patient (Circle One): Father Mother Guardian

Last Name: First Name: Middle Name:

****SEND ALL OUT-OF-STATE IMMUNIZATION RECORDS WITH THIS FORM****

- **Option 1: Fax** to 352-620-6824; please do not include a cover sheet.
- **Option 2: Mail** to Florida Department of Health in Marion County, ATTN: Immunizations, 1801 SE 32nd Ave., Ocala, FL 34471.
- **Option 3: Email** to dlchd42immunizations@flhealth.gov. **Please note:** Since most written communications to or from state officials about state business are public records, your email communication may therefore be subject to public disclosure.
- **Option 4: Drop off in Person** at our main location, 1801 SE 32nd Ave., Suite 400, Ocala, FL 34471.