ROLLING MEADOWS HIGH SCHOOL
ALUMNI IMMUNIZATION REQUEST FORM

A photocopy of your current Driver’s License or State Identification must be submitted with this form.

Number of copies requested   $10.00 each

Print current information

Name _______________________ Maiden ___________ Graduation Year _________
Address ______________________ __________________________ Date of Birth __________
City, State, Zip ___________________________ Phone ______________
Signature of Alumni (not parent) ___________________________ Date __________

I give permission to mail my high school immunization record to:

Name __________________________________________
Attention __________________________________________
Address __________________________________________
City, State, Zip __________________________

PLEASE NOTE:
* Mail your request form (verbal, faxed or e-mail requests are not accepted).
* Only you can request/sign for your immunization record to be released.
* Requests will not be processed without a completed form that includes your signature, payment and a photo ID.

MAIL TO: Rolling Meadows High School
Attention: Registrar
2901 W. Central Rd.
Rolling Meadows, IL 60008

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OFFICE USE ONLY

Date Received ________________ Total Fee Received __________ Date Mailed ________________

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