Community High School District 94
326 Joliet Street
West Chicago, IL 60185
PH: (630) 876-6200
FAX: (630) 876-6241

I hereby request that Community High School District 94, West Chicago, Illinois,

Release the health/immunization records of _____
(Student Name)

_____ _____ _____
(ID #) *(Date of Birth)* *(Graduation Date)*

TO:_____

_____

_____

_____ _____
(Date of Request) **(Signature of Parent/Student)*

**Parents signature is required if the student is under eighteen (18) years of age. Student signature is required if the student is eighteen (18) years of age or older.*

THERE IS A FEE OF $5.00 PER COPY OF IMMUNIZATION RECORDS FOR ALL FORMER STUDENTS.