

I, _____, give [Name of School], permission to release the following information concerning my child, _____, to the

Name of Child

Indiana State Department of Health's Children and Hoosiers Immunization Registry Program (CHIRP):

CHILD'S NAME, IMMUNIZATION DATA, SEX, ETHNICITY, PARENT'S NAMES, ADDRESS, AND PHONE

I understand that the information in the registry may be used to verify that my child has received proper immunizations and to inform me or my child of my child's immunization status or that an immunization is due according to recommended immunization schedules.

I understand that my child's information may be available to the immunization data registry of another state, a healthcare provider or a provider's designee, a local health department, an elementary or secondary school, a child care center, the office of Medicaid policy and planning or a contractor of the office of Medicaid policy and planning, a licensed child placing agency, and a college or university. I also understand that other entities may be added to this list through amendment to I.C. 16-38-5-3.

I hereby consent to the release of such information.

Signature

Date

Printed Name of Parent or Guardian

Address

Telephone Number

Child's Name

Date of Birth



Community
Health Network

**Indiana State Department of Health
Children & Hoosiers Immunization Registry Program
CHIRP**

School

Grade