Josh Mullis
Principal

Darla Holt
Admin Assistant

Shoals Middle School

Jessica Hert
Counseling

Stacey Fox
Student Services

I, _____, give the Shoals Community schools, permission to release the
(Parent or Guardian Name)
following information concerning my child, _____, to the Indiana State Department of
(Name of Child)
Health's children and Hoosiers Immunization Registry Program (CHIRP):

STUDENT'S NAME--DATE OF BIRTH--IMMUNIZATION DATE

PARENTS OR GUARDIAN NAME--ADDRESS

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 Phone number

_____ _____
Child's Name Grade Level