

Shoals Community School Corporation

11741 Ironton Road
Shoals, Indiana 47581
Telephone (812)247-2060
Fax (812)247-2278

I, _____, give the Shoals Community Schools, permission to release the following information concerning my child, _____, to the Indiana State Department of Health's Children and Hoosier Immunization Registry Program (CHIRP):

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

Child's Name

Grade