



INDIANAPOLIS PUBLIC SCHOOLS
INDIANA IMMUNIZATION REGISTRY
PARENT AUTHORIZATION

I, _____, give the Indianapolis Public Schools permission to release the following information concerning my child,

Name of Child Birthdate

to the Indiana State Department of Health Children and Hoosiers Immunization Registry Program (CHIRP):

Name, Date of Birth, Immunization Data Guardian's Name, Other Identifying Information as applicable

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 will be available to the immunization data registry of another state, a healthcare provider, a local health department, an elementary or secondary school attended by my child, a child care center, and the office of Medicaid policy and planning or a contractor of the office of Medicaid policy and planning. I also understand that other entities may be added to this list through an amendment to IC 16-38-5-3.

I hereby consent to the release of such information.

Signature Date

Printed Name Address

Child's Name School

