

## Bartholomew County Health Department

By signing below, I give the Bartholomew County Health Department permission to release the following information concerning my child to the Indiana State Department of Health's Children and Hoosiers Immunization Registry Program (CHIRP).

I understand that the information in the registry may be used to verify that my child has received proper immunizations and to inform me of my child's immunization status or that an immunization is due according to the 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 second school, a child care center, the office of Medicaid policy and planning or a contactor 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 of I.C. 16-38-5-3.

I hereby consent to the release of such information. **I will provide all information that follows.**

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Parent or Guardian

\_\_\_\_\_  
Address

( ) \_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
City and Zip Code

\_\_\_\_\_  
Child's First, Middle and Last Name

\_\_\_\_\_  
Child's Date of Birth

\_\_\_\_\_  
Ethnic Background of Child

\_\_\_\_\_  
School Name

\_\_\_\_\_  
Grade Level

Please provide a current record of immunizations, if it has not already been submitted to the school.

**PLEASE RETURN THIS FORM TO THE SCHOOL OFFICE**