CONSENT TO RELEASE INFORMATION TO THE CHILDREN AND HOOSIER IMMUNIZATION REGISTRY PROGRAM

Student's Name _____
(last name) (first name) (middle name)

Date of Birth _____

Parent or Guardian _____

Address _____

City _____ State _____ Zip Code _____

Phone Number _____

I request and authorize Seymour Community Schools to release immunization information for my child to the Children and Hoosiers Immunization Registry Program and or to the child's healthcare provider as needed.

Signed on _____
(month/day/year)

_____ ___ _____
Signature of parent or Guardian relationship to student

*Notice: The Children and Hoosiers Immunization Registry Program keeps a record of immunizations that are entered into the Children and Hoosiers Immunization Registry Program system by participating providers, health plans, vital records and Medicaid. You may ask us for a copy of your record or your children's record. You may also ask us to correct the record. If you have any questions you may contact the Children and Hoosiers Immunization Registry Program Support Center at 1-888-227-4439.