CHIRP Parent Consent Form

I, _____ give PLA permission to release the following information concerning
(Name of Parent/Guardian)

my child _____ to the Indiana State Department of Health's Children and
(Name of Child)

Hoosiers Immunization Registry Program (CHIRP). This information includes name, immunization data and date of birth. ***School may provide additional details on information being shared in the space below (if 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 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 Telephone Number

_____ _____
Child's Name Grade Level

_____
PLA Network School