MSD Health Services

I, _____, give the MSD Nurses **permission to release the following information** concerning my child _____to the Indiana State Department of Health's Children and Hoosiers Immunization Registry Program (CHIRP): **Name, Date of Birth, Immunizations.**

I understand that the information in the registry may be used to verify that my child has received proper immunizations, to inform me or my child of my child's immunization status, or to verify 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 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 though amendment to I.C. 16-38-5-3.
I hereby consent to the release of such information.

_____ _____

Signature Date

_____ _____

Printed Name of Parent of Guardian Telephone Number

_____

Address

_____ _____

Child's Name Current Grade

_____

School