

Indiana School for the Deaf

Health Center

Health Center
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CHIRP Entry Permission Form

I hereby give my permission to the Health Center staff of the Indiana School for the Deaf to release the following information concerning my child, _____ to the Indiana State

Department of Health's Children and Hoosiers Immunization Registry Program (CHIRP):

Information needed for this registry will include name, date of birth, immunization historical dates and any other information that may be needed to correctly identify the student.

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 that is attended by the individual, 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 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