METROPOLITAN SCHOOL DISTRICT OF MT. VERNON
1000 WEST FOURTH STREET, MT. VERNON, INDIANA 47620-1696
PHONE 812-833-5114, FAX 812-833-2078
www.msdmv.k12.in.us

CHIRP Release Form

I, _____, give the M.S.D. of Mt. Vernon, permission to release the following information concerning my child(ren) to the Indiana State Department of Health's Children and Hoosiers Immunization Registry Program (CHIRP):

Child's name, birth date, immunization dates, address, telephone number, race, and guardian name.

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 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 IC 16-38-5-3.

Children's Name	**School Attending**	**Grade**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I hereby consent to the release of such information.

Parent/Guardian Signature: _____ Date: _____

Printed Parent/Guardian Name: _____

Address: _____ Telephone: (___)_____

_____ _____