



SOUTH BEND COMMUNITY SCHOOL CORPORATION
 215 S. Dr. Martin Luther King Jr. Blvd. South Bend, Indiana 46601
 TELEPHONE: (574) 393-6000

Dear Parent/Guardian,

The Indiana State Department of Health has implemented an electronic reporting system that is designed to improve the state's records on immunizations. The registry is called Children and Hoosiers Immunization Registry Program (**CHIRP**). Health care providers in Indiana will enter data into the electronic database to ensure the most up-to-date record of immunizations is available.

Recently the Indiana Department of Education mandated that Indiana schools document annual immunization records through CHIRP and we are required to submit immunization reports in order to maintain the accreditation of our schools. This letter is to notify you of this change and to ask your permission to submit the immunization status of your child electronically. If you have questions about this document, please contact the health office in your child's school.

I give the South Bend Community School Corporation permission to release the following information concerning my child _____ to the Indiana State Department of Health's Children and Hoosiers Immunization Registry Program (CHIRP):

Student's Name, Address, Phone Number, Date of Birth, Immunization Data, Parent's Name, School Name, Grade Level

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, and elementary or secondary school, a child care center, the office of Medical 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 Ind. Code 16-38-5-3.

I hereby consent to the release of such information.

Signature

Date

Printed Name of Parent or Guardian

(__) _____
Telephone Number

Child's Name

Date of Birth

School

Grade Level

PLEASE RETURN FORM TO THE HEALTH OFFICE IN YOUR CHILD'S SCHOOL