



Release of Immunization Information

I am the (parent)(natural guardian) of \_\_\_\_\_, a minor. I hereby consent to and authorize the Department of Health and its agents and/or employees to release information on this minor to authorities at her/his school and to her/his physician for the purpose of determining immunization status or providing immunizations.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date