

Authorization for Release of Immunization Information

Please complete this form and return to the school office by Friday, December 16, 2011.

Student Information:

List each student(s):

Grade	Last Name	First Name	Birthdate

Student(s) Address(s): _____

Parent/Guardian Information:

Parent/Guardian Name: _____

Address (if different than above): _____

Phone: (_____) _____

Check one:

I hereby authorize Jefferson County North School District #339 to release immunization information relating to the above-named student(s) to the Kansas Immunization Registry.

I do not authorize Jefferson County North School District #339 to release immunization information relating to the above-named student(s) to the Kansas Immunization Registry.

I affirm that I am authorized to consent to release of medical information on the behalf of the student. I understand that this authorization will expire when the student is no longer enrolled in the above-named school and that I may revoke this authorization in writing at any time.

Parent/Guardian Signature: _____

Relationship to student: _____

Date: _____

For statistical purposes, please indicate your student's insurance carrier:

No Insurance Medicaid, Healthwave
(Children's Mercy/FHP, Unicare) Other Private Insurance,
Please list name: _____