SAMPLE TEXT
PARENT/GUARDIAN CONSENT

Authorization for Release of Immunization Information

The purpose of disclosure is to establish an electronic immunization information system that will provide a complete and permanent record for your child. This information will be shared with health care providers to help prevent both over and under-immunization and to develop one consolidated vaccine record for the child.

Name of student: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Date of Birth: _____

I hereby authorize (School District Name) to release immunization information to the Virginia Immunization Information System (VIIS).

Parent / Guardian Signature: _____Date: _____