

USD #421 Immunization Record Release

School required immunizations are tracked by using the confidential statewide immunization registry. This enables complete immunization records to be permanently stored in one secure location.

Student Information

First name: _____ Last name: _____ Grade: _____ Birthdate: _____

First name: _____ Last name: _____ Grade: _____ Birthdate: _____

First name: _____ Last name: _____ Grade: _____ Birthdate: _____

Student Address

Street: _____ City: _____

State: _____ Zip code: _____

Parent Information

First name: _____ Last name: _____

Phone number: (____) _____

Parent Address (if different than above)

Street: _____ City: _____

State: _____ Zip code: _____

I authorize the school district to release immunization information relating to the above-named student(s) to the Kansas Immunization Registry.

I do not authorize the school district 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 behalf of the above-named student(s). I understand that this authorization will expire when the student is no longer enrolled in the school and that I may revoke this authorization in writing at any time.

Parent/guardian signature: _____ Date signed: _____