WICHITA PUBLIC SCHOOLS
Division of Student Support Services
DEPARTMENT OF HEALTH SERVICES

Authorization for the Release of Immunization Records and Information

Student Name – _____ Student ID – _____

School – _____

This form below must be signed by *one or both parent(s) or guardian(s)*.
Please return the form to the **school office** where it will be kept on file.

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I/We do hereby authorize any entity subject to HIPAA laws and regulations to release records and information regarding immunizations received by the above-named student to Unified School District No. 259, Sedgwick County, Kansas, to permit the student's enrollment and attendance at school.

This authorization continues until such time as the student reaches eighteen (18) years of age or until I/we exercise our right to revoke this authorization in writing and present it to the party in possession of the records and/or information.

Signed this _____ day of _____, 20__.

_____ _____
Parent/Guardian Name (Print) Parent/Guardian Signature

_____ _____
Parent/Guardian Name (Print) Parent/Guardian Signature
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