

**PARENT RETURN THIS FORM TO SCHOOL**

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If you wish us to notify your child's health care provider that your child has received this vaccine, please complete the top portion of this form and sign. Incomplete forms will not be forwarded to the health care provider.

**AUTHORIZATION FORM FOR RELEASE OF PROTECTED HEALTH INFORMATION**

I hereby authorize LaSalle County Health Department and LaSalle County School Health Service to release my child's record of immunization given at the School Clinic to their current health care provider who is:

Physician/Health Care Provider's Name: \_\_\_\_\_

Physician/Health Care Provider's Phone: \_\_\_\_\_

Physician/Health Care Provider's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

From the records of:

\_\_\_\_\_ whose birthdate is \_\_\_\_\_  
(Child's Full Name)

This authorization for release of protected health information terminates January 1, 2012.

Parent's Signature or Personal Representative \_\_\_\_\_ Date: \_\_\_\_\_

**TO BE FILLED OUT BY NURSE**

Physician/Health Care Provider the above child listed has received the following immunization from LaSalle County Health Department or LaSalle County School Service.

This Child received **Tdap** immunization on **DATE:** \_\_\_\_\_

Given by \_\_\_\_\_ LaSalle County Health Dept./LaSalle County Health Service  
(Nurse's Signature)

Provider any questions please contact the LaSalle County Health Department at 815-433-3366.