NEW JERSEY IMMUNIZATION INFORMATION SYSTEM (NJIIS)
CONSENT TO PARTICIPATE

CHILD INFORMATION *(please print)*	**PARENT/GUARDIAN INFORMATION**
Name	Name
Date of Birth	Relationship
Address	Address

I have read the information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to keep a central record of my child's immunization history and to remind me when immunizations are due. I understand that I can obtain a copy of my child's record from my medical provider, my local health department, or my child's school nurse.

There is no cost to participate in this program.

☐ Yes, I would like to participate in this program.

☐ No, I do not wish to participate in this program.

Signature of Parent / Guardian	Date

New Jersey Department of Health and Senior Services
Vaccine Preventable Diseases Program
PO Box 369
Trenton, NJ 08625-0369

PLEASE RETURN THIS FORM TO YOUR CHILD'S SCHOOL NURSE WITHIN 7 DAYS