Arkansas School for the Deaf

2400 W. Markham • Little Rock, Arkansas • 72205 • (501) 324-9506 • Fax (501) 324-9553

Johnny Key
Secretary

Dr. Janet Dickinson
Superintendent

School Immunization Clinic

I, _____, give
Parent/Guardian Name

permission for my child,_____ to
First and Last Name

participate in the School Immunization Clinic for the recommended and required immunizations.

In compliance with the Family Education Right to Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99)

I, _____,give permission to enter my
Parent/Guardian Name

child's_____ immunizations given at the Arkansas School for the
First and Last Name

Deaf in the Arkansas Department of Health WEBIZ.

Parent/Guardian Signature_____

Date Signed _____