Request to be Reinstated/ Participate in the Impact Statewide Immunization Information System (ImpactSIIS)

In order to be reinstated into the immunization registry and appointment reminder system, called ImpactSIIS, the Ohio Department of Health must receive this form signed by the patient, or if the patient is a minor, the parent or legal guardian. Immunization data for the patient listed below will be made available to health care providers. Accuracy of an individual's immunization records should be checked by a health care provider. We accept immunization records only from health care providers or a party's insurance carrier. At all times access to an individual's immunization record is protected, made available only to health care providers and school nurses.

PLEASE PRINT. Use formal names with nicknames in parentheses, for example, William (Bill).

Patient's Information:

Name (Last, First and Middle): _____, _____ _____

Address: _____

City:_____ State: _____ Zip: _____-_____

Date of Birth: __ __ / __ __ /__ __ __ __ Social Security Number*: __ __ __ - __ __ - __ __ __ __

Telephone Number: (__ __ __) __ __ __ - __ __ __

Mother's (or Guardian's) Information

Name (Last, First and Middle): _____, _____ _____

Date of Birth: __ __ / __ __ /__ __ __ __ Social Security Number*: __ __ __ - __ __ - __ __ __ __

Maiden Name: _____

Father's (or Guardian's) Information

Name (Last, First and Middle): _____, _____ _____

Date of Birth: __ __ / __ __ /__ __ __ __ Social Security Number*: __ __ __ - __ __ - __ __ __ __

* Supplying the Social Security Numbers is optional.

By completing and signing this form, I am requesting to be reinstated into the Ohio Department of Health's ImpactSIIS. If I am signing on behalf of a minor, I certify that I am legally authorized, under penalty of law, to exercise the rights of the minor identified in this document.

Signature: _____

Date: __ __ / __ __ /__ __ __ __

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