

Northeast Wyoming Pediatric Associates, P.C.  
Barry M. Wohl, M.D.,  
Suzanne E.K. Oss, M.D.,  
Marilyn K. Horsley, P.A.-C,  
Deborah L. Mullinax, P.A.-C  
916 Jackson Avenue  
Sheridan, WY 82801  
(307) 672-6451

**CONSENT TO IMMUNIZE and CONSENT TO BE IN THE WYOMING REGISTRY**

	Name of Patient	Birthdate
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____
9.	_____	_____
10.	_____	_____

By signing below, I give my permission to provide my infant, child or self (named above) with all current and future immunizations appropriate for his/her age and give permission to release the record to health, human service and educational providers. I understand that my doctor or physician assistant or nurse will ask for verbal permission before each immunization is administered.

I understand that the state of Wyoming maintains an immunization registry. The benefits of the registry are to prevent duplication of immunizations, provide parents with timely notification of immunizations due, and to serve as a backup in case you lose your child's record of vaccination. Immunization records are only accessible by authorized healthcare providers, human service providers, and schools.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_