Virginia Immunization Information System (VIIS)
Opt-In of VIIS

This form is required to allow a person who has previously opted-out of VIIS to opt back into VIIS thereby allowing collection if immunization data on the person.

Name of Client: _____ _____ _____
LAST FIRST MIDDLE

Date of Birth: _____ **Sex**: _____ **Race**: _____
MM/DD/YYYY M/F

Name of Parent or Guardian: _____ _____ _____
LAST FIRST MIDDLE

Relation: _____ **Telephone Number**: _____ _____
PARENT OR GUARDIAN AREA CODE NUMBER

Street Address: _____

City: _____ **State**: _____ **ZIP**: _____

I request this person be reinstated into the Virginia Immunization Information System (VIIS). I understand this action will allow the state to add all immunization data on this person from participating providers in VIIS. VIIS will be the official source of immunization history for this person.

This Opt-In form will be maintained in the Virginia Department of Health, Division of Immunization Program's office. The Virginia Department of Health, Division of Immunization Program must receive a completed Opt-In form before action is taken to add the person into VIIS.

_____ _____
SIGNATURE (Parent or Guardian if client is a minor) DATE (MM/DD/YYYY)

THIS FORM MUST BE COMPLETED AND MAILED TO THE FOLLOWING ADDRESS:

VIIS Opt-In
Virginia Department of Health
Division of Immunization
109 Governor Street, Room 314W
Richmond, VA 23219