CHILDREN AND HOOSIER IMMUNIZATION REGISTRY PROGRAM (CHIRP) VACCINE ADMINISTRATION

RECORD OF PARENT/GUARDIAN OR RECEIPT SIGNATURE

I have read or had explained to me the information in the 'Vaccine Information Statement(s)" or the "Important Information Statement(s)" for the disease(s) and vaccine(s) checked below. I have had a chance to ask questions and fully understand the benefits and risks of the vaccine(s) checked below. I request that these vaccines be given to me or to the person named below.

☐DT	☐DTaP/IPV	☐ DTaP-HiB	☐ Influenza .50 ml	☐MMR	☐HEP B	☐PCV 20	☐HPV 9v
☐Td	☐DTaP/IPV/Hep B	☐IPV	☐RIV4	☐MMRV	☐HEP A	☐PCV 15	☐Rotavirus
☐Tdap	☐DTaP/IPV/HiB	☐HiB	☐Flu Mist	☐Varicella	☐HEP A (Adult)	☐PCV 13	☐MCV 4
☐DTaP	☐DTaP/IPV/HiB/Hep B		☐High Dose	☐Zoster	☐COVID-19	☐PPSV23	☐Men B

Last Name:	First:		Middle:	Gender: ☐M ☐F ☐Other
Date of Birth:	Age:	Birth State:	Birth Country	Hoosier Healthwise #
Race: ☐White ☐African American ☐Asian ☐Multi-Racial ☐Other ☐Nat. Hawaiian, Pac. Islander. ☐American Indian				Hispanic Origin: ☐Hispanic ☐Non-Hispanic ☐Unknown
Physician Name:				School District Reside In:
Guardian 1 Last Name:	First:			Relationship: ☐Mother ☐Father ☐Other(specify)_____
Guardian 2 Last Name:	First:			Mother Maiden Name:
Mailing Address:				
Address:			Home Phone:	Work Phone:
City:	State:	ZIP Code:	Email Address:	
Language, if other than English (specify):			Other Phone (specify):	

Clinic Use Only: Funding Source: O Medicaid O Underinsured - FQHC or RHC Only O Uninsured O Hoosier HWise Pkg C O Nat. American or Alaskan O Ineligible O 317

I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical benefits to the Health Department responsible for today's services.

I agree to receive text, voice, and email messages from the Health Department to the phone number(s) and email provided above. Message and data rates may apply.

Signature of person to receive vaccine(s) or person authorized to consent to the immunization(s).

_____
Parent/Guardian/Patient Signature

_____
Printed Name

_____
Date

Children & Hoosiers Immunization Registry Program (CHIRP)

Countermeasures Injury Compensation Program (CICP)

Updated: 06/21/2023

VACCINE ADMINISTRATION
PATIENT RECORD

Last Name:	First Name:	Middle Name:	Patient ID:
Date of Birth:	Age:	Contraindication:	
DO NOT WRITE BELOW THIS LINE - For Clinic Use Only			
Clinic:		Date Vaccinated: Date VIS Provided to Parent/Guardian/Patient:	

Vaccine	Dose	Manufacturer & Lot #	Route/Site	Date of VIS & Date VIS Given
DTaP, Tdap, Td				
Hep B				
IPV				
MMR				
HIB				
Varicella				
PCV				
Meningococcal				
Influenza				
Hep A				
HPV				
Covid				
DTaP, IPV, HIB, Hep B				
DTaP, IPV, HIB				
DTaP, Hep B, IPV				
MMR, Varicella				
DTaP, IPV				

X _____Signature and Title of Vaccine Administrator