

**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.

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

Last Name:		First:		Middle:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other
Date of Birth:	Age:	Birth State:	Birth Country:	Hoosier Healthwise #	
Race: <input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other <input type="checkbox"/> Nat. Hawaiian, Pac. Islander. <input type="checkbox"/> American Indian				Hispanic Origin: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown	
Physician Name:			School District Reside in:		
Guardian 1 Last Name:		First:		Relationship: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> 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: <input type="checkbox"/> Medicaid <input type="checkbox"/> Uninsured <input type="checkbox"/> Nat. American or Alaskan Funding Source: <input type="checkbox"/> Underinsured - FQHC or RHC Only <input type="checkbox"/> Hoosier HWise Pkg C <input type="checkbox"/> Ineligible <input type="checkbox"/> 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 provide above. Message and data rates may apply.

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

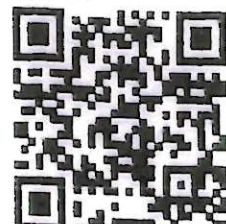
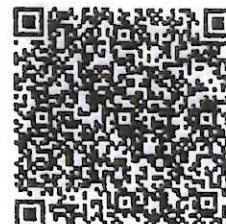
Parent/Guardian/Patient Signature

Printed Name

Date

Children & Hoosiers
Immunization
Registry
Program (CHIRP)

Countermeasures
Injury
Compensation
Program (CICP)



Screening Checklist for Contraindications to Vaccines for Children and Teens

PATIENT NAME _____

DATE OF BIRTH _____ / _____ / _____
month day year

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Is the child sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the child have allergies to medications, food, a vaccine component, or latex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the child had a serious reaction to a vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the child have a long-term health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is he/she on long-term aspirin therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. If your child is a baby, have you ever been told he or she has had intussusception?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Does the child have a parent, brother, or sister with an immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Has the child received vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FORM COMPLETED BY _____

DATE _____

FORM REVIEWED BY _____

DATE _____

Did you bring your immunization record card with you? yes ☐ no ☐

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.

immunization
action coalition

A
immunize.org

Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

www.immunize.org/catg.d/p4060.pdf • Item #P4060 (10/20)

Vaccines For Children (VFC) - Patient Eligibility Screening Form

1. Screening Date ____ / ____ / 20__

2. Child's Name _____
Last Name First Name MI

3. Child's Date of Birth ____ / ____ / ____

Below is for office staff only

Does this patient qualify for vaccines through the Vaccines For Children Program? (check only one):

- ☐ The child has any form of Medicaid insurance.
- ☐ The child does not have insurance.
- ☐ The child is underinsured (has health insurance that does not pay for vaccinations).
- ☐ The child has private insurance and doesn't qualify.

Eligibility					
Date	Eligibility Status Change	Screener Initials	Uninsured	Underinsured	Does not meet eligibility criteria
	Y or N				
	Y or N				
	Y or N				
	Y or N				
	Y or N				
	Y or N				
	Y or N				
	Y or N				
	Y or N				

Signature of staff completing form:

Date: