CHIRP

Children and Hoosiers Immunization Registry Program

CHILDREN AND HOOSIER IMMUNIZATION REGISTRY PROGRAM (CHIRP)

RECORD OF PARENT/GUARDIAN OR RECIPIENT SIGNATURE

I have read or had explained to me the information in the "Vaccine Information Statement(s)"(VIS) 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.

☐ TD ☐ DTap ☐ Tdap ☐ Mening B ☐ PPSV23 ☐ Hep B ☐ Hib ☐ MMR ☐ IPV

☐ Varicella ☐ PCV-__ ☐ MCV4 ☐ Influenza ☐ Rotavirus ☐ HPV ☐Zoster ☐ Hep A ☐ Other

Last Name:	First Name:	Middle Name:	Date of Birth:	Age:
Alias Last Name:	Alias First Name:			
Birth State:	Birth Country:	Hoosier Hwise #:		Gender:

Race:
O White O African American O Asian O Multi-racial O Other
O Nat. Hawaiian, Pac Isl O American Indian

Hispanic Origin:
O Hispanic O Non-Hispanic
O Unknown

Language if other than English:

Physician Name:		School:	
Guardian 1 Last Name:	First Name:	Middle Name:	
Guardian 2 Last Name:	First Name:	Mothers Maiden Name:	

Mailing Address for Responsible Adult: O Mother O Father O Other (specify) _____

Last Name:		First Name:	
Address:		Home / Cell Phone:	Work Phone:
City:	State: Zip:	Email Address:	

For Clinic Use Only: Funding Source:
O Medicaid O Uninsured O Nat. American or Alaskan O Underinsured FQHC Only
O Hoosier HWise Pkg C O Not Eligible O 317

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you or your child. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by asking for an updated copy.

By signing the patient registration form: 1) You consent to our use and disclosure of protected health information about you or your child for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. 2) You consent to receive the recommended immunizations. 3) You consent to receiving information on CHIRP, Countermeasures injury compensation program (CICP), and Vaccine information statements (VIS) on the recommended immunizations.

Children and Hoosiers Immunization Registry Program (CHIRP)

Countermeasures Injury Compensation Program (CICP)

_____

Patient/Parent/Guardian Signature

_____

Printed Name

_____

Date

DO NOT GO BELOW THIS LINE - FOR CLINIC USE ONLY

Clinic: Harrison County Health Department **Corydon, IN 47112 812.738.3237**	**Date Vaccinated:** **Date VIS Provided to Parent/Guardian/Patient:**

Vaccine	Manufacturer, Lot #, & Expiration	Route/Site	Date of VIS
DTaP Tdap Td			
IPV			
Rotavirus			
HiB			
Prevnar			
MMR			
Varicella			
Hep A			
HPV			
Hep B			
Dtap/IPV/HBV			
Dtap/HiB/IPV			
MCV4			
Influenza			
Meningococcal B			
Zoster			
OTHER VACCINES			

X _____

Signature and Title of Vaccine Administrator