CHILDREN AND HOOSIERS IMMUNIZATION REGISTRY PROGRAM (CHIRP)

VACCINE ADMINISTRATION RECORD OF PARENT/GUARDIAN OR RECIPIENT SIGNATURE

PATIENT ID

☐ Covid	☐ Td	☐ Tdap	☐ DTaP	☐ DTaP/Hep B/IPV	☐ Hep B	☐ DTaP/IPV	☐ Hib
☐ MMR	☐ IPV	☐ Varicella	☐ PCV	☐ MCV	☐ Influenza	☐ Hep A	☐ MMR/Varicella
☐ Rotavirus	☐ HPV	☐ Men B	☐ DTaP/IPV/HIB	☐DTaP/IPV/Hib/Hep B	☐ Insert	☐ Insert	☐

Last Name:	First Name:	Middle Name:	Date of Birth:	Patient ID:
Alias Last Name:	Alias First Name:		Age:	
Birth State:	Birth Country:	Medicaid #, if applicable:		Gender:
Race: ◯ White ◯ African American ◯ Asian ◯ Multi-Racial ◯ Nat. Hawaiian, Pac Isl. ◯ American Indian ◯ Other			Hispanic Origin: ◯Hispanic ◯Non-Hispanic ◯ Unknown	
Physician Name:	Mother's Maiden Name:		School:	
Guardian 1 Last Name:		First Name:	Middle Name:	
Guardian 2 Last Name:		First Name:	Middle Name:	
Mailing Address for Responsible Adult: ◯ Mother ◯ Father ◯ Other (specify) ______				
Last Name:			First Name:	
Address:			Home Phone:	Work Phone:
City:	State:	Zip:	Email Address:	
Language, if other than English (specify):			Other Phone (specify):	
(CLINIC USE ONLY)	Chart Number:			
Funding Source ◯ Medicaid ◯ Uninsured ◯Nat. American or Alaskan ◯ Underinsured ◯ Medicaid Package C - CHIP ◯ Not Eligible/Private Insurance				

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

____
Patient/Parent/Guardian Signature

______________________________ ______________
Printed Name *Date*

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