CHIRP
Children and Hoosiers Immunization Registry Program

CHILDREN AND HOOSIERS IMMUNIZATION REGISTRY PROGRAM (CHIRP)

VACCINE ADMINISTRATION RECORD OF PARENT/GUARDIAN OR RECEIPT SIGNATURE

PATIENT ID

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 name below.

☐ DT ☐ Td ☐ DTaP ☐ Tdap ☐ DTaP-Hib ☐ DTaP/Hep B/IPV ☐ Hep B ☐ Hep B/Hib ☐ Hib ☐ MMR ☐ IPV
☐ Varicella ☐ PCV-7 ☐ MCV4 ☐ Influenza ☐ Hep A ☐ MMR/Varicella ☐ Rotavirus ☐ HPV

Last Name:	First Name:	Middle Name:	Date of Birth:	Patient ID:
Alias Last Name:	Alias First Name:	Patient SSN *:	Age:	
Birth State:	Birth Country:	Hoosier Hwise #:	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 1 SSN*:
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 - FQHC or RHC Only ◯ Hoosier HWise Pkg C ◯ Not Eligible

* Social Security Numbers may be used to identify patient and family members and are optional on this form. There are no penalties for failure to provide Social Security Numbers.

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

_____
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	Manf. & Lot #	Route/Site	Date of VIS
DT Td DTaP Tdap				
Hep B				
IPV				
MMR				
HIB				
Varicella				
PCV-7				
MCV4				
Influenza				
Hep A				
MMR/Varicella				

X _____

Signature and Title of Vaccine Administrator