



CHILDREN AND HOOSIER IMMUNIZATION REGISTRY PROGRAM (CHIRP)
 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 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 Rotavirus HPV MMR/V Hep A

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: M <input type="radio"/> F <input type="radio"/>	
Race: <input type="radio"/> White <input type="radio"/> African American <input type="radio"/> Asian <input type="radio"/> Multi-racial <input type="radio"/> Other <input type="radio"/> Nat. Hawaiian, Pac Isl. <input type="radio"/> American Indian						Hispanic Origin: <input type="radio"/> Hispanic <input type="radio"/> Non-Hispanic <input type="radio"/> Unknown			
Physician Name:						School:			
Guardian 1 Last Name:				First Name:		Middle Name:		Guardian 1 SSN*:	
Guardian 2 Last Name:				First Name:		Mothers Maiden Name:			
Mailing Address for Responsible Adult: <input type="radio"/> Mother <input type="radio"/> Father <input type="radio"/> Other(specify) _____									
Last Name:						First Name:			
Address:						Home Phone:		Work Phone:	
City:		State:		Zip:		Email Address:			
Language, if other than English (specify):						Other Phone:			
CLINIC USE ONLY		Chart Number:							
Funding Source: <input type="radio"/> Medicaid <input type="radio"/> Uninsured <input type="radio"/> Nat. American or Alaskan <input type="radio"/> Underinsured FQHC Only <input type="radio"/> Hoosier Hwise Pkg C <input type="radio"/> Not Eligible									
* Social Security Numbers may be used to identify patients and family members and are optional on this form. There are no penalties for failure to provide SSN.									

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

Parent/Guardian Signature

Printed Name

Date

Patient name: _____

Date of birth: ____/____/____
(mo.) (day) (yr.)

Screening Questionnaire for Child and Teen Immunization

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. Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? 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 between the ages of 2 and 4 years, 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, AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. In the past 3 months, has the child taken cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. 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"/>
11. 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"/>
12. 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 child's 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 a personal record, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep this record in a safe place and bring it with you every time you seek medical care for your child. Your child will need this important document for the rest of his or her life to enter day care or school, for employment, or for international travel.