CHIRP
Children and Hoosiers Immunization Registry Program

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.

Insurance Status: ○ Uninsured ○ Nat. American or Alaskan ○ Underinsured ○ Private Insurance ○ Medicaid # _____			
Last Name:	**First Name:**	**Middle Name:**	**Date of Birth:**
Alias Last Name:	**Alias First Name:**	**Age:**	
Birth State:	**Birth Country:**	**Gender:** ○ M ○ F	
Race: ○ White ○ African American ○ Asian ○ Multi-racial ○ Nat. Hawaiian, Pac Isl. ○ American Indian ○ Other			**Hispanic Origin:** ○ Hispanic ○ Non-Hispanic ○ Unknown
School:			
Guardian 1 Last Name:		**First Name:**	**Middle Name:**
Guardian 2 Last Name:		**First Name:**	**Mothers Maiden 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:**

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

_____
Parent/Guardian Signature

_____ _____
Printed Name *Date*