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 ○ F ○
Race: ○ White ○ African American ○ Asian ○ Multi-racial ○ Other ○ Nat. Hawaiian, Pac Isl. ○ American Indian			Hispanic Origin: ○ Hispanic ○ Non-Hispanic ○ 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: ○ 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:	
CLINIC USE ONLY	Chart Number:			
Funding Source: ○ Medicaid ○ Uninsured ○ Nat. American or Alaskan ○ Underinsured FQHC Only ○ Hoosier HWise Pkg C ○ Not Eligible				
* Social Security Numbers may be used to identify patients and family members and are optional on this form. There are no penalites 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*