



**CHILDREN AND HOOSIER IMMUNIZATION REGISTRY PROGRAM (CHIRP)  
VACCINE ADMINISTRATION  
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 named below.

DT	Td	DTaP	DTaP-Hib	DTaP/HepB/IPV	Hib	IPV	MMR	HEP B	Varicella	Hib/Hep B	PCV-7	
Last Name:		First:		Middle:		Patient ID:		Patient SSN*:				
Date of Birth:		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:			Middle:		Guardian 1 SSN*:			
Guardian 2 Last Name:				First:			Mother Maiden Name:					
Mailing Address for Responsible Adult: Mother Father Other (specify) _____												
Last Name:						First Name:						
Address:						Home Phone:			Work Phone:			
City:		State:		ZIP Code:		Email Address:						
Language, if other than English (specify):						Other Phone (specify):						
<b>(Clinic use only)</b>		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 immunizations(s)

\_\_\_\_\_  
*Parent/Guardian Signature*

\_\_\_\_\_  
*Printed Name*

\_\_\_\_\_  
*Date*