Indiana Department of Health – Registration and Consent Form

Phone:	Complete the following for the person who is being vac Patient Name: FIRST MIDDLE	cinated:	LAST		
Mailing Address:					
Parent/Quardian Full Name:					
Race: (Check all that apply) "MO INSURANCE "MEDICAID Company: Medicaid #:					
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Company: Medicaid #: PRIVATE or COMMERCIAL INSURANCE (NOT MEDICAID) Attach a copy of cord to form if possible					
□ PRIVATE or COMMERCIAL INSURANCE (NOT MEDICAID) Attach a copy of card to form if possible Company: Policy Holder Name: Policy Holder Relationship to Patient: Policy Holder Relationship to Patient: Patient Screening Questions for the Person Cetting Vaccinated: 1. Is the person sick today? If yes, what are their symptoms? 2. Any allergies to medication, foods, a vaccine component, or latex? Please list allergies: 2. Any allergies to medication, foods, a vaccine component, or latex? Please list allergies: 3. Has the person ever had a serious reaction to a vaccine in the past? If yes, please explain: 3. Has the person ever had a serious reaction to a vaccine in the past? If yes, please explain: 4. Has the person ever had doulillan-Barre Syndrome (GBS)? 5. Does the person have a long-term health problem with heart, lung or kidney disease, metabolic disease (e.g., diabetes), anemia or other blood disorders (e.g. sickle cell)? 6. Does the person have cancer, leukemia, AIDS or any other immune system concerns? Consent Statement (onlinued on other side) 8. Signing below, I consent to the use and disclosure of my or my child's personal health information for the purpose of health care operations, along with the assignment of all payments from the insurer listed above to Indiana Department of Health (IDOH) and VaxCare for the services rendered. Consent for Use of Protected Health Information & Claims Assignment: I hereby consent to and acknowledge the receipt of a Notice of Privacy Practices regarding the use and disclosure of my personal health information for the purpose of health care operations, along with the assignment of all payment from the insurer listed above to VaxCare associated with the services rendered. Consent for Use of Protected Health Information & Claims Assignment: I hereby consent to and acknowledge the receipt of a Notice of Privacy Practices regarding the use and disclosure of my personal health information for the purpose of health care operations, along with the assignment of all paym					
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Health Screening Questions for the Person Getting Vaccinated: 1. Is the person sick today? If yes, what are their symptoms? 2. Any allergies to medication, foods, a vaccine component, or latex? Please list allergies: 3. Has the person ever had a serious reaction to a component, or latex? Please list allergies: 3. Has the person ever had a serious reaction to a characteristic or anticancer drugs, or have had x-ray treatments for cancer? 3. Has the person ever had a serious reaction to a characteristic or anticancer drugs, or have had x-ray treatments for cancer? 3. Has the person ever had Guillian-Barre Syndrome characteristic or some present or is the person pregnant or is there a chance they could become pregnant during the next month? 4. Has the person have a long-term health problem with the person preson and the person pregnant or is there a chance they could become pregnant during the next month? 4. Has the person have a long-term health problem with the person pregnant or is there a chance they could become pregnant during the next month? 4. Has the person have a long-term health problem with the person pregnant or is the person received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin? sickle cell? 5. Does the person have cancer, leukemia, AIDS or any cherical person preceived any vaccinations in the person received any vaccinations in the past 4 weeks? Consent Statement (continued on other side) 8. Discussion of blood or blood products, or been given a medicine called immune (gamma) globulin? sickle cell? 6. Does the person have cancer, leukemia, AIDS or any cherical person received any vaccinations in the past 4 weeks? Consent for Use of Protected Health Information & Claims Assignment: I hereby consent to and acknowledge the receipt of a Notice of Privacy Practices regarding the use and disclosure of my personal health information for the purpose of health care operations, along with the assignment of all payments from the insurer listed a					
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shall be entitled to join or consolidate claims in arbitration by or against other individuals or entities or arbitrate any claims as a representative member of a class or in private attorney general capacity. In the case of the occupational exposure, IDOH has patient's permission for blood testing for patient and employee safety alike. I have read or have had explained to me the information from the Vaccine Information Statement(s) and understand the risks (including adverse reactions) and benefits of the vaccine(s). If consenting for another, I have the legal authority, based on my relationship to the individual indicated above, to consent to this vaccine(s) administration. I consent to myself/my child being vaccinated with all recommended vaccinations that are due at this time. If I want to refuse any specific vaccine(s), then I will call 317-519-2079 or email: mlayman@isdh.in.gov Vaccines that may be administered based on you/your child's vaccination record: DTaP/Tdap, Hepatitis A, Hepatitis B, Haemophilus influenzae type b (HIB), Human Papilloma Virus (HPV), Influenza, MMR, Meningitis, Polio, Pneumonia, Rotavirus, Varicella, and Covid-19. Signature: X					
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Parent/Guardian cianature required if under 19 years old					
	Parent/Guardian cianatura required if under 10	ld			

Indiana Department of Health – Registration and Consent Form

CLINIC USE ONLY Note any vaccine refusals next to vaccine name							
Vaccine	VIS	MANUFACTURER/LOT #/ EXP DATE	INJEC	TION SITE	ROUTE		
Dtap	8/6/21		□ L arm	□ R arm	□ IM		
(Infanrix)			☐ L thigh	□ R thigh			
Dtap/IPV	4/1/20		□ L arm	□ R arm	□IM		
(Kinrix)	1, 1, 20		☐ L thigh	□ R thigh			
Dtap/HepB/IPV	4/1/20		□ L arm	□ R arm	□IM		
(Pediarix)	1, 1, 20		☐ L thigh	□ R thigh			
Dtap/IPV/Hib/HepB	4/1/20		□ L arm	□ R arm	□IM		
(Vaxelis)	., _, _		☐ L thigh	□ R thigh			
Нер А	7/28/20		□ L arm	□ R arm	□IM		
□ adult □ pediatric	., _0, _0		☐ L thigh	☐ R thigh			
Нер В	8/15/19		□ L arm	□ R arm	□IM		
□ adult □ pediatric	0, 10, 10		☐ L thigh	□ R thigh			
Hib (Pedvax)	4/1/20		□ L arm	□ R arm	□IM		
This (i cavax)	7/1/20		☐ L thigh	□ R thigh	L 11V1		
HPV (Gardasil 9)	8/6/21		□ L arm	□ R arm	□IM		
Influenza			□ L arm	□ R arm			
IIIIuciiza	8/6/21		□ L thigh	□ R thigh	□IM		
MCV4			- L tiligii	- IN CITIEST			
(Menactra)	8/6/21		□ L arm	□ R arm	□IM		
Men B							
Wiell D	8/6/21		□ L arm	□ R arm	□ IM		
MMR	0/6/04		□ L arm	□ R arm			
	8/6/21		□ L thigh	☐ R thigh	□ SC		
MMRV	0/6/04		□ L arm	□ R arm			
(ProQuad)	8/6/21		□ L thigh	☐ R thigh	□ SC		
PCV13	2/2/24		□ L arm	□ R arm			
	8/6/21		☐ L thigh	☐ R thigh	□IM		
Polio	2/2/24		□ L arm	□ R arm	□IM		
	8/6/21		☐ L thigh	☐ R thigh	□ SC		
PPSV23	10/30/19		□ L arm	□ R arm	□ IM		
<u> </u>							
Rotavirus	10/30/19				□РО		
(Rotateq)							
Tdap	8/6/21		□ L arm	□ R arm	□IM		
(Boostrix)							
Varicella	8/6/21		□ L arm	□ R arm	□ SC		
			□ L thigh	□ R thigh			
0 1140							
Covid-19	*EAU		□ L arm	□ R arm	□IM		
VACCINATOR NAME AND		S. DAT]		
	1	DAT					

	-, -,			□ L thigh	□ R thigh
Covid-19	*EAU			□ L arm	□ R arm
VACCINATOR NAME AND	CREDENTIA	S:	DAT	E:	
Checked out in Vaxcare o	n:	Initials:	<u>—</u>		