English

Indiana Immunization Coalition (IIC) – Registration and Consent Form

6919 E 10th Street, Suite C2, Indianapolis, IN 46219

Complete the following for the person who is being vaccinated:

Patient Legal Name: First _____ Middle _____ Last: _____

Chosen Name (*if applicable*): _____ **Occupation** (*if applicable*): _____

Phone #: (_____) - _____ - _____ **DOB:** _____ /_____/_____ **Age:** _____ **Sex** (assigned at birth): □ F □ M **Pronouns:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **ZIP Code:** _____

Race: (Check all that apply) □American Indian/Alaskan Native □Asian □Black □Native Hawaiian/Pacific Islander □White □Other _____

Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino **Parent/Guardian Full Name:** _____

For students: School Name: _____ Grade level: _____

Insurance Status (Check box)

□ NO INSURANCE

□ MEDICAID □ HHW □ HCC □ HIP □ CHIP

Company: _____

Medicaid #: _____

□ MEDICARE

Medicare #: _____

Member ID / Group # (if applicable): _____

□ PRIVATE or COMMERCIAL INSURANCE (NOT MEDICAID) *Attach a copy of card to form if possible*

Company: _____ Policy/Member ID: _____ Group #: _____

Policy Holder Name: _____ Policy Holder Birth Date: ____/_____/_____

Policy Holder Relationship to Patient: _____

Health Screening Questions for the Person Getting Vaccinated:

1. Are you sick today?	□ No □ Yes
2. Any allergies to medication, foods, a vaccine ingredient, or latex? Please list allergies:	□ No □ Yes
3. Have you ever had a serious reaction after receiving a vaccine? If yes, please explain:	□ No □ Yes
4. Have you ever had Guillain-Barre Syndrome (GBS)?	□ No □ Yes
5. Do you have a long-term health problem with heart, lung or kidney disease, metabolic disease (e.g. diabetes) or other blood disorders (e.g. clotting disorder, sickle cell)?	□ No □ Yes
6. Do you have cancer, leukemia, AIDS or any other immune system concerns?	□ No □ Yes
7. Have you had a seizure or a brain or other nervous system problem?	□ No □ Yes
8. Do you take cortisone, prednisone, other steroids or anticancer drugs, or have had x-ray treatments for cancer?	□ No □ Yes
9. For women- is the person pregnant or is there a chance they could become pregnant during the next month?	□ No □ Yes
10. Do you smoke or vape? Have you ever smoked or vaped?	□ No □ Yes
11. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	□ No □ Yes
12. Have you received any vaccinations in the past 4 weeks?	□ No □ Yes

Consent Statements

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 third party biller associated with the services contemplated herein.

***Signature: X** _____ **Date:** _____

Parent/Guardian signature required if under 18 years old

Vaccine Authorization: My signature on this form indicates that I have requested that the vaccine indicated below be administered to me or my dependent by an Indiana Immunization Coalition (IIC) representative. I relieve third party biller, IIC, the administering person and personnel of any liability for any reactions that should occur. I unconditionally and irrevocably waive any right to a trial by jury, to the maximum extent allowed by law, for any claim or action arising out of or related to this service, and that any such claim or action shall be determined solely on an individual basis through arbitration in accordance with Commercial Arbitration Rules of the American Arbitration Association. Neither I nor IIC or third party biller 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 an occupational exposure, IIC has the 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 317-628-7116, email: clinic@vaccinateindiana.org or discuss with on-site clinic lead.

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 Papillomavirus (HPV), Influenza, MMR, Meningitis, Polio, Pneumonia, Rotavirus, Respiratory Syncytial Virus (RSV), Varicella, Zoster, and/or Covid-19.

***Signature: X** _____ **Date:** _____

Parent/Guardian signature required if under 18 years old

English

INDIANA IMMUNIZATION COALITION

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CLINIC USE ONLY *Note any vaccine refusals next to vaccine name*				
Vaccine	**VIS**	**MANUFACTURER/LOT #/ EXP DATE**	**INJECTION SITE**	**ROUTE**
Dtap	8/6/21		□ L arm □ R arm □ L thigh □ R thigh	□ IM
Dtap/IPV	8/6/21		□ L arm □ R arm □ L thigh □ R thigh	□ IM
Dtap/Hep B/IPV	5/12/23		□ L arm □ R arm □ L thigh □ R thigh	□ IM
Dtap/Hib/IPV	10/15/21		□ L arm □ R arm □ L thigh □ R thigh	□ IM
Dtap/IPV/Hib/HepB	5/12/23		□ L arm □ R arm □ L thigh □ R thigh	□ IM
Hep A □ adult □ pediatric	10/15/21		□ L arm □ R arm □ L thigh □ R thigh	□ IM
Hep B □ adult □ pediatric	5/12/23		□ L arm □ R arm □ L thigh □ R thigh	□ IM
Hib	8/6/21		□ L arm □ R arm □ L thigh □ R thigh	□ IM
HPV	8/6/21		□ L arm □ R arm	□ IM
Influenza	8/6/21		□ L arm □ R arm □ L thigh □ R thigh	□ IM
MCV4	8/6/21		□ L arm □ R arm	□ IM
Men B	8/6/21		□ L arm □ R arm	□ IM
MMR	8/6/21		□ L arm □ R arm □ L thigh □ R thigh	□ SC
MMRV	8/6/21		□ L arm □ R arm □ L thigh □ R thigh	□ SC
Pneumococcal	5/12/23		□ L arm □ R arm □ L thigh □ R thigh	□ IM
Polio	8/6/21		□ L arm □ R arm □ L thigh □ R thigh	□ IM □ SC
Rotavirus	10/15/21			□ PO
RSV	10/19/23		□ L arm □ R arm	□ IM
Tdap	8/6/21		□ L arm □ R arm	□ IM
Varicella	8/6/21		□ L arm □ R arm □ L thigh □ R thigh	□ SC
Zoster	2/4/22		□ L arm □ R arm	□ IM
Covid-19	10/19/23		□ L arm □ R arm	□ IM

VACCINATOR NAME AND CREDENTIALS: _____ DATE: _____

Checked out in third party biller on: _____ Initials: _____

Revised 2/20/2024 SJ