



## Indiana Immunization Coalition (IIC) – Registration and Consent Form

6919 E 10<sup>th</sup> 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  
**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?  | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 2. Any allergies to medication, foods, a vaccine ingredient, or latex? Please list allergies:   | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 3. Have you ever had a serious reaction after receiving a vaccine? If yes, please explain:  | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 4. Have you ever had Guillain-Barre Syndrome (GBS)?   | <input type="checkbox"/> No <input type="checkbox"/> 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)? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 6. Do you have cancer, leukemia, AIDS or any other immune system concerns?  | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 7. Have you had a seizure or a brain or other nervous system problem?   | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 8. Do you take cortisone, prednisone, other steroids or anticancer drugs, or have had x-ray treatments for cancer?  | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 9. For women- is the person pregnant or is there a chance they could become pregnant during the next month?   | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 10. Do you smoke or vape? Have you ever smoked or vaped?  | <input type="checkbox"/> No <input type="checkbox"/> 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?                               | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 12. Have you received any vaccinations in the past 4 weeks?   | <input type="checkbox"/> No <input type="checkbox"/> 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](mailto: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***CLINIC USE ONLY - Note any vaccine refusals next to vaccine name**



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Vaccine	VIS	MANUFACTURER/LOT #/ EXP DATE	INJECTION SITE	ROUTE
<b>Dtap</b> 6 weeks - 6 years	8/6/21		<input type="checkbox"/> L arm <input type="checkbox"/> R arm <input type="checkbox"/> L thigh <input type="checkbox"/> R thigh	<input type="checkbox"/> IM
<b>Dtap/IPV</b> 4 years - 6 years	1/31/25		<input type="checkbox"/> L arm <input type="checkbox"/> R arm <input type="checkbox"/> L thigh <input type="checkbox"/> R thigh	<input type="checkbox"/> IM
<b>Dtap/Hep B/IPV</b> 6 weeks-6 years	1/31/25		<input type="checkbox"/> L arm <input type="checkbox"/> R arm <input type="checkbox"/> L thigh <input type="checkbox"/> R thigh	<input type="checkbox"/> IM
<b>Dtap/Hib/IPV</b> 6 weeks - 4 years	1/31/25		<input type="checkbox"/> L arm <input type="checkbox"/> R arm <input type="checkbox"/> L thigh <input type="checkbox"/> R thigh	<input type="checkbox"/> IM
<b>Dtap/IPV/Hib/HepB</b> 6 weeks - 4 years	1/31/25		<input type="checkbox"/> L arm <input type="checkbox"/> R arm <input type="checkbox"/> L thigh <input type="checkbox"/> R thigh	<input type="checkbox"/> IM
<b>Hep A</b> <input type="checkbox"/> adult 19 yr and up <input type="checkbox"/> pediatric 1 yr - 18 yr	1/31/25		<input type="checkbox"/> L arm <input type="checkbox"/> R arm <input type="checkbox"/> L thigh <input type="checkbox"/> R thigh	<input type="checkbox"/> IM
<b>Hep B (2 dose series)</b> 18 years and up	1/31/25		<input type="checkbox"/> L arm <input type="checkbox"/> R arm <input type="checkbox"/> L thigh <input type="checkbox"/> R thigh	<input type="checkbox"/> IM
<b>Hep B (3 dose series)</b> <input type="checkbox"/> adult 20 yrs and up <input type="checkbox"/> pediatric Birth-19 yrs	1/31/25		<input type="checkbox"/> L arm <input type="checkbox"/> R arm <input type="checkbox"/> L thigh <input type="checkbox"/> R thigh	<input type="checkbox"/> IM
<b>Hib</b> 6 weeks - 4 years	8/6/21		<input type="checkbox"/> L arm <input type="checkbox"/> R arm <input type="checkbox"/> L thigh <input type="checkbox"/> R thigh	<input type="checkbox"/> IM
<b>HPV</b> 9 yrs - 45 yrs	8/6/21		<input type="checkbox"/> L arm <input type="checkbox"/> R arm	<input type="checkbox"/> IM
<b>Influenza</b> 6 mos and up High Dose - 65yrs & up	1/31/25		<input type="checkbox"/> L arm <input type="checkbox"/> R arm <input type="checkbox"/> L thigh <input type="checkbox"/> R thigh	<input type="checkbox"/> IM
<b>MCV4</b> 1st dose: 10-15 yrs 2nd dose: 16 and up	1/31/25		<input type="checkbox"/> L arm <input type="checkbox"/> R arm	<input type="checkbox"/> IM
<b>Men B</b> 16 yrs - 23 yrs Bexsero / Trumenba	1/31/25		<input type="checkbox"/> L arm <input type="checkbox"/> R arm	<input type="checkbox"/> IM
<b>MMR</b> 1 year - 64 years	1/31/25		<input type="checkbox"/> L arm <input type="checkbox"/> R arm <input type="checkbox"/> L thigh <input type="checkbox"/> R thigh	<input type="checkbox"/> SC
<b>MMRV</b> 3 yrs - 12 yrs	1/31/25		<input type="checkbox"/> L arm <input type="checkbox"/> R arm <input type="checkbox"/> L thigh <input type="checkbox"/> R thigh	<input type="checkbox"/> SC
<b>Pneumococcal</b> 6 weeks - 4 years 50 years and up	5/12/23		<input type="checkbox"/> L arm <input type="checkbox"/> R arm <input type="checkbox"/> L thigh <input type="checkbox"/> R thigh	<input type="checkbox"/> IM
<b>Polio</b> 6 weeks and up	1/31/25		<input type="checkbox"/> L arm <input type="checkbox"/> R arm <input type="checkbox"/> L thigh <input type="checkbox"/> R thigh	<input type="checkbox"/> IM <input type="checkbox"/> SC
<b>Rotavirus</b> 6 weeks - 8 mos.	10/15/21			<input type="checkbox"/> PO
<b>RSV</b> Infants - 19 mos. 60 yrs and up	1/31/25		<input type="checkbox"/> L arm <input type="checkbox"/> R arm	<input type="checkbox"/> IM
<b>Tdap</b> 7 years and up	1/31/25		<input type="checkbox"/> L arm <input type="checkbox"/> R arm	<input type="checkbox"/> IM
<b>Varicella</b> 1 year and up	1/31/25		<input type="checkbox"/> L arm <input type="checkbox"/> R arm <input type="checkbox"/> L thigh <input type="checkbox"/> R thigh	<input type="checkbox"/> SC
<b>Zoster</b> 50 yrs and up	2/4/22		<input type="checkbox"/> L arm <input type="checkbox"/> R arm	<input type="checkbox"/> IM
<b>COVID</b>	1/31/25		<input type="checkbox"/> L arm <input type="checkbox"/> R arm	<input type="checkbox"/> IM

VACCINATOR NAME AND CREDENTIALS: \_\_\_\_\_ DATE: \_\_\_\_\_