



Indiana Immunization Coalition (IIC) – Registration and Consent Form

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

ከታች የተጠየቁትን መረጃዎች ክትባት ለሚሰጠው ሰው ያስገቡ፦	
የታከሚው ሕጋዊ ስም፦ መጠሪያ ስም _____ የአባት ስም _____ የእያት ም፦ _____ የተመረጠ ስም (እግባብ ከሆነ)፦ _____ የሙያ ዘርፍ (እግባብ ከሆነ)፦ _____ ስልክ _____ ቁጥር፦ (____) - _____ የትውልድ ቀን፦ ____/____/____ ልደሜ፦ _____ ያታ (ሲወለዱ የተመደበልዎ ያታ)፦ <input type="checkbox"/> ሴ <input type="checkbox"/> ወ የፖስታ አድራሻ፦ _____ ከተማ፦ _____ ለስቲት፦ _____ ዚፕ ኮድ፦ _____ ዘር፦ (እግባብ የሆኑት ላይ በሙሉ ምልክት ያድርጉ) <input type="checkbox"/> ኔቲቭ ሕንድ/የአላስካ ኔቲቭ <input type="checkbox"/> እስያዊ <input type="checkbox"/> ጥቁር <input type="checkbox"/> ኔቲቭ ሃዋይያን/ፓሲፊክ አይላንደር <input type="checkbox"/> ነጭ <input type="checkbox"/> ሌላ ብሔር፦ <input type="checkbox"/> ሂስፓኒክ/ላቲኖ <input type="checkbox"/> ሂስፓኒክ/ላቲኖ አይደለሁም የወላጅ/አሳዳጊ ሙሉ ስም፦ _____ ለተማሪዎች፦ የትምህርት ቤት ስም፦ _____ የክፍል ደረጃ፦ _____	
የመድኃኒ ሁኔታ (አመልካች ሳጥን)	
<input type="checkbox"/> መድኃኒ የለውም/የላትም	
<input type="checkbox"/> MEDICAID <input type="checkbox"/> HHW <input type="checkbox"/> HCC <input type="checkbox"/> HIP <input type="checkbox"/> CHIP ኩባንያ፦ _____ የMedicaid ቁጥር፦ _____	<input type="checkbox"/> MEDICARE የMedicare ቁጥር፦ _____ የአባል መታወቂያ / የቡድን ቁጥር (እግባብ ከሆነ)፦ _____
<input type="checkbox"/> የግል ወይም የንግድ መድኃኒ (MEDICAID ያልሆነ) ከተቻለ የካርዱን ቅጂ ከቅፁ ጋር ተያያዥ ያድርጉ ኩባንያ፦ _____ ፖሊሲ/የአባል መታወቂያ፦ _____ የቡድን ቁጥር፦ _____ የፖሊሲው ባለቤት ስም፦ _____ የፖሊሲው ባለቤት የትውልድ ቀን፦ ____/____/____ የፖሊሲው ባለቤት ከታከሚው ጋር ያለው ዝምድና/ግንኙነት፦ _____	
ክትባት ለሚሰጠው ሰው የሚቀርቡ የጤና ማግሪያ ጥያቄዎች፦ (no) (yes)	
1. ዛሬ ታምመዋል?	<input type="checkbox"/> አይ <input type="checkbox"/> አዎ
2. ለመድኃኒቶች፣ ለምግቦች፣ ለክትባት ንጥረ ነገሮች ወይም ለላቲክስ አለርጂዎች አሉዎት? እባክዎ አለርጂዎቹን ከታች ይዘርዝሩ፦	<input type="checkbox"/> አይ <input type="checkbox"/> አዎ
3. ክትባት ከወሰዱ በኋላ እደገኛ ምልክቶችን ያዩባቸው እጋጣሚዎች ነበሩ? መልስዎ አዎ ከሆነ፣ እባክዎ ማብራሪያ ይስጡበት፦	<input type="checkbox"/> አይ <input type="checkbox"/> አዎ
4. የጃሊያንባሬ ሲንድረም (GBS) ፕሮብዎት ያውቃል?	<input type="checkbox"/> አይ <input type="checkbox"/> አዎ
5. ለረዥም ጊዜ የቆየ የልብ፣ የሳንባ ወይም የኩላሊት በሽታ ወይም እንደ ስኳር በሽታ ያለ የሰውነት ሚታባሊዝም በሽታ ወይም ደግሞ እንደ ደም መርጋት ችግር እና/ወይም ሲክል ሴል ያሉ ሌሎች የደም በሽታዎች አሉብዎት?	<input type="checkbox"/> አይ <input type="checkbox"/> አዎ
6. ካንሰር፣ ሉኪሚያ፣ ኢድስ ወይም በሽታ የመከላከል አቅም የሚያዳክም በሽታ ስጋት አሉብዎት?	<input type="checkbox"/> አይ <input type="checkbox"/> አዎ
7. የሚጥል በሽታ ወይም የአእምሮ ወይም ሌላ የነርቭ ሥርዓት ችግር ነበረብዎት?	<input type="checkbox"/> አይ <input type="checkbox"/> አዎ
8. የኮርቲዞን፣ ፕሪድኒሶን ወይም ሌሎች የስቲሮይድ ወይም የካንሰር መከላከያ መድኃኒቶችን እየወሰዱ ወይም ከዚህ ቀደም ለካንሰር ሕክምና የወሰዱቸው የኤክስሬይ ሕክምናዎች አሉ?	<input type="checkbox"/> አይ <input type="checkbox"/> አዎ
9. ለሴቶች፦ ግለሰቧ በአሁኑ ጊዜ ነፍሰ ጡር ናት ወይም በቀጣዩ ወር ውስጥ ነፍሰ ጡር ልትሆን የምትችልበት እጋጣሚ አለ?	<input type="checkbox"/> አይ <input type="checkbox"/> አዎ
10. ሲጋራ ወይም ቪፕ ያጫሳሉ? ሲጋራ ወይም ቪፕ እጭሰው ያውቃሉ?	<input type="checkbox"/> አይ <input type="checkbox"/> አዎ
11. ባለፈው እንደ ዓመት ውስጥ የደም ወይም የደም ምርቶች ዝውውር ተሰጥቶዎት ወይም የበሽታ መከላከያ (ጋማ) ግለብዉሊን ወይም ፀረ-ቫይረስ መድኃኒት ተሰጥቶዎት ያውቃል?	<input type="checkbox"/> አይ <input type="checkbox"/> አዎ
12. ባለፉት 4 ሳምንታት ውስጥ የተሰጡዎት ክትባቶች አሉ?	<input type="checkbox"/> አይ <input type="checkbox"/> አዎ



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ደህንነታቸው የተጠበቀ የጤና መረጃዎችን ለመጠቀም እና የዕዳ ክፍያ የመጠየቅ መብት ለማዘዋወር ፈቃድ መስጫ፡ የግላዊነት ማስታወቂያ መቀበሉን በዚህ አስማማቂ ለሆኑ እና እውቅና አሰጣለሁ

የግል የጤና መረጃዬን ለጤና አጠባበቅ ሥራዎች ዓላማ ለመጠቀም እና ለማሳወቅ የሚደረጉ ልምድ ዶክተር፣ ከዚህ በላይ ከተዘረዘሩት የመድረክን ሰጪሁሉንም ክፍያ በዚህ ውስጥ ከተመለከቱት አገልግሎቶች ጋር ለተያያዙ የሦስተኛ ወገን ክፍያ አቅራቢዎች መስጠት።

***ፊርማ፡- X** **ቀን፡**

ከ18 ዓመት በታች ከሆኑ የወላጅ/አሳዳጊ ፊርማ ያስፈልጋል

የክትባት ፈቃድ መስጫ፡ በዚህ ቅፅ ላይ ያሰፈርኩት ፊርማ ከታች የተጠቀሰው ክትባት ለእኔ ወይም ለጥገኛዬ በIndiana Immunization Coalition (IIC) ተወካይ እንዲሰጥ መጠየቁን ያመለክታል። ሦስተኛ ወገን ክፍያ አስፈጻሚውን፣ IIC፣ ክትባት ሰጪውን ሰው እና ሠራተኛ

ሊያጋጥሙ ከሚችሉ ማናቸውም ዓይነት የጎንዮሽ ጉዳቶች ተጠያቂነት ነፃ አድርጌያለሁ። ከዚህ አገልግሎት ወይም ከዚህ አገልግሎት ጋር ተያይዞ ህግ በሚፈቅደው ክፍተት መጠን

ለሚጠየቅ ማንኛውም ይግባኝ ወይም ለሚወሰድ እርምጃ በዓኖች ችሎት የማግኘት ማንኛውንም መብት ያለ ምንም ቅድመ ሁኔታ እና በማይሻር ሁኔታ ትቼያለሁ።

እንዲሁም ዓይነቱ ይግባኝ ወይም እርምጃ በAmerican Arbitration Association (አሜሪካ የዳኝነት ማህበር) የንግድ ዳኝነት ሕጎች መሰረት በግለሰብ ደረጃ ውሳኔ የሚተላለፍበት ይሆናል።

እኔ ወይም IIC ወይም የሦስተኛ ወገን ክፍያ አስፈጻሚው በሌሎች ግለሰቦች ወይም ተቋማት ላይ ወይም በእነሱ የሚጠየቁ የዳኝነት ይግባኞችን የመቀላቀል ወይም የመዋሃድ ወይም ደግሞ የእንደ ቡድን ተወካይ አባል በመሆን ወይም የግል ጠበቃ በመሆን ማናቸውንም ይግባኝ ጥያቄዎች የመዳኘት መብት እይናረንም። ባለሙያ ተጋላጭ በሚሆን ጊዜ ለታካሚው እንዲሁም ለሠራተኛ የጋራ ደኅንነት ሲባል IIC የደም ምርመራ እንዲያደርግ ታካሚው ፈቃድ ሰጥተውታል።

የክትባት መረጃ መግለጫውን/ዎቹን እንብቢያለሁ ወይም ደግሞ በውስጡ ያሉ መረጃዎች እንዲበራረዱ አድርጌያለሁ፤ የጎንዮሽ ጉዳቶችንም ምርመራ ከክትባቱ/ቶቹ ጋር ተያይዞ የሚኖሩ ስጋሮችን እና የሚገኙ ጥቅሞችን ተረድቼያለሁ። ፈቃድ እየሰጠሁ ያለሁት ለሌላ ሰው ከሆነ፣ ከላይ በተመለከተው መሠረት

ከግለሰብ ጋር ካለኝ ግንኙነት በመነሳት ክትባቱ እንዲሰጥ ፈቃድ የመስጠት ሕጋዊ ሥልጣን አለኝ።

በዚህ ጊዜ እንዲሰጡ የሚመከሩ ሁሉም ክትባቶች ለእኔ/ለልጄ እንዲሰጡ ፈቃድ አሰጣለሁ። ማንኛውንም ዓይነት ክትባት/ቶች መውሰድ ካልፈለግኩ ወደ 317-628-7116 እደውላለሁ፤ clinic@vaccinateindiana.org እሚያል አደርጋለሁ ወይም በአካል ከሚገኝ የክሊኒክ ኃላፊ ጋር እወያያለሁ። በእርስዎ/በልጅዎ የክትባት መዝገብ መሠረት ሊሰጡ የሚችሉ ክትባቶች፡ ዲ.ቲ.ኤ.ፒ/ቲ.ዲ.ኤ.ፒ፣ ሂፒቪ-1/2/3/4/5/6/7/8/9/10/11/12/13/14/15/16/17/18/19/20/21/22/23/24/25/26/27/28/29/30/31/32/33/34/35/36/37/38/39/40/41/42/43/44/45/46/47/48/49/50/51/52/53/54/55/56/57/58/59/60/61/62/63/64/65/66/67/68/69/70/71/72/73/74/75/76/77/78/79/80/81/82/83/84/85/86/87/88/89/90/91/92/93/94/95/96/97/98/99/100/101/102/103/104/105/106/107/108/109/110/111/112/113/114/115/116/117/118/119/120/121/122/123/124/125/126/127/128/129/130/131/132/133/134/135/136/137/138/139/140/141/142/143/144/145/146/147/148/149/150/151/152/153/154/155/156/157/158/159/160/161/162/163/164/165/166/167/168/169/170/171/172/173/174/175/176/177/178/179/180/181/182/183/184/185/186/187/188/189/190/191/192/193/194/195/196/197/198/199/200/201/202/203/204/205/206/207/208/209/210/211/212/213/214/215/216/217/218/219/220/221/222/223/224/225/226/227/228/229/230/231/232/233/234/235/236/237/238/239/240/241/242/243/244/245/246/247/248/249/250/251/252/253/254/255/256/257/258/259/260/261/262/263/264/265/266/267/268/269/270/271/272/273/274/275/276/277/278/279/280/281/282/283/284/285/286/287/288/289/290/291/292/293/294/295/296/297/298/299/300/301/302/303/304/305/306/307/308/309/310/311/312/313/314/315/316/317/318/319/320/321/322/323/324/325/326/327/328/329/330/331/332/333/334/335/336/337/338/339/340/341/342/343/344/345/346/347/348/349/350/351/352/353/354/355/356/357/358/359/360/361/362/363/364/365/366/367/368/369/370/371/372/373/374/375/376/377/378/379/380/381/382/383/384/385/386/387/388/389/390/391/392/393/394/395/396/397/398/399/400/401/402/403/404/405/406/407/408/409/410/411/412/413/414/415/416/417/418/419/420/421/422/423/424/425/426/427/428/429/430/431/432/433/434/435/436/437/438/439/440/441/442/443/444/445/446/447/448/449/450/451/452/453/454/455/456/457/458/459/460/461/462/463/464/465/466/467/468/469/470/471/472/473/474/475/476/477/478/479/480/481/482/483/484/485/486/487/488/489/490/491/492/493/494/495/496/497/498/499/500/501/502/503/504/505/506/507/508/509/510/511/512/513/514/515/516/517/518/519/520/521/522/523/524/525/526/527/528/529/530/531/532/533/534/535/536/537/538/539/540/541/542/543/544/545/546/547/548/549/550/551/552/553/554/555/556/557/558/559/560/561/562/563/564/565/566/567/568/569/570/571/572/573/574/575/576/577/578/579/580/581/582/583/584/585/586/587/588/589/590/591/592/593/594/595/596/597/598/599/600/601/602/603/604/605/606/607/608/609/610/611/612/613/614/615/616/617/618/619/620/621/622/623/624/625/626/627/628/629/630/631/632/633/634/635/636/637/638/639/640/641/642/643/644/645/646/647/648/649/650/651/652/653/654/655/656/657/658/659/660/661/662/663/664/665/666/667/668/669/670/671/672/673/674/675/676/677/678/679/680/681/682/683/684/685/686/687/688/689/690/691/692/693/694/695/696/697/698/699/700/701/702/703/704/705/706/707/708/709/710/711/712/713/714/715/716/717/718/719/720/721/722/723/724/725/726/727/728/729/730/731/732/733/734/735/736/737/738/739/740/741/742/743/744/745/746/747/748/749/750/751/752/753/754/755/756/757/758/759/760/761/762/763/764/765/766/767/768/769/770/771/772/773/774/775/776/777/778/779/780/781/782/783/784/785/786/787/788/789/790/791/792/793/794/795/796/797/798/799/800/801/802/803/804/805/806/807/808/809/810/811/812/813/814/815/816/817/818/819/820/821/822/823/824/825/826/827/828/829/830/831/832/833/834/835/836/837/838/839/840/841/842/843/844/845/846/847/848/849/850/851/852/853/854/855/856/857/858/859/860/861/862/863/864/865/866/867/868/869/870/871/872/873/874/875/876/877/878/879/880/881/882/883/884/885/886/887/888/889/890/891/892/893/894/895/896/897/898/899/900/901/902/903/904/905/906/907/908/909/910/911/912/913/914/915/916/917/918/919/920/921/922/923/924/925/926/927/928/929/930/931/932/933/934/935/936/937/938/939/940/941/942/943/944/945/946/947/948/949/950/951/952/953/954/955/956/957/958/959/960/961/962/963/964/965/966/967/968/969/970/971/972/973/974/975/976/977/978/979/980/981/982/983/984/985/986/987/988/989/990/991/992/993/994/995/996/997/998/999/1000/1001/1002/1003/1004/1005/1006/1007/1008/1009/1010/1011/1012/1013/1014/1015/1016/1017/1018/1019/1020/1021/1022/1023/1024/1025/1026/1027/1028/1029/1030/1031/1032/1033/1034/1035/1036/1037/1038/1039/1040/1041/1042/1043/1044/1045/1046/1047/1048/1049/1050/1051/1052/1053/1054/1055/1056/1057/1058/1059/1060/1061/1062/1063/1064/1065/1066/1067/1068/1069/1070/1071/1072/1073/1074/1075/1076/1077/1078/1079/1080/1081/1082/1083/1084/1085/1086/1087/1088/1089/1090/1091/1092/1093/1094/1095/1096/1097/1098/1099/1100/1101/1102/1103/1104/1105/1106/1107/1108/1109/1110/1111/1112/1113/1114/1115/1116/1117/1118/1119/1120/1121/1122/1123/1124/1125/1126/1127/1128/1129/1130/1131/1132/1133/1134/1135/1136/1137/1138/1139/1140/1141/1142/1143/1144/1145/1146/1147/1148/1149/1150/1151/1152/1153/1154/1155/1156/1157/1158/1159/1160/1161/1162/1163/1164/1165/1166/1167/1168/1169/1170/1171/1172/1173/1174/1175/1176/1177/1178/1179/1180/1181/1182/1183/1184/1185/1186/1187/1188/1189/1190/1191/1192/1193/1194/1195/1196/1197/1198/1199/1200/1201/1202/1203/1204/1205/1206/1207/1208/1209/1210/1211/1212/1213/1214/1215/1216/1217/1218/1219/1220/122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Indiana Immunization Coalition (IIC) – Registration and Consent Form

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

CLINIC USE ONLY - Note any vaccine refusals next to vaccine name

Vaccine	VIS	MANUFACTURER/LOT #/ EXP DATE	INJECTION SITE	ROUTE
Dtap 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
Dtap/IPV 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
Dtap/Hep B/IPV 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
Dtap/Hib/IPV 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
Dtap/IPV/Hib/HepB 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
Hep A <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
Hep B (2 dose series) 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
Hep B (3 dose series) <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
Hib 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
HPV 9 yrs - 45 yrs	8/6/21		<input type="checkbox"/> L arm <input type="checkbox"/> R arm	<input type="checkbox"/> IM
Influenza 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
MCV4 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
Men B 16 yrs - 23 yrs Bexsero / Trumenba	1/31/25		<input type="checkbox"/> L arm <input type="checkbox"/> R arm	<input type="checkbox"/> IM
MMR 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
MMRV 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
Pneumococcal 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
Polio 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
Rotavirus 6 weeks - 8 mos.	10/15/21			<input type="checkbox"/> PO
RSV Infants - 19 mos. 60 yrs and up	1/31/25		<input type="checkbox"/> L arm <input type="checkbox"/> R arm	<input type="checkbox"/> IM
Tdap 7 years and up	1/31/25		<input type="checkbox"/> L arm <input type="checkbox"/> R arm	<input type="checkbox"/> IM
Varicella 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
Zoster 50 yrs and up	2/4/22		<input type="checkbox"/> L arm <input type="checkbox"/> R arm	<input type="checkbox"/> IM
COVID	1/31/25		<input type="checkbox"/> L arm <input type="checkbox"/> R arm	<input type="checkbox"/> IM

VACCINATOR NAME AND CREDENTIALS: _____ DATE: _____