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** Company: _____ Medicaid #: _____	□ **Medicare** Medicare #: _____ Member ID / Group # (*if applicable*): _____

□ **Private, Commercial, or Supplemental Insurance** (NOT MEDICAID) *Attach a copy of card to form if possible*

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

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

Policy Holder Relationship to Patient: _____

Health Screening Questions for the Person Getting Vaccinated:

1. Is the person sick today? If yes, what are their symptoms?	□ No □ Yes
2. Any allergies to medication, foods, a vaccine component, or latex? Please list allergies:	□ No □ Yes
3. Has the person ever had a serious reaction to a vaccine in the past? If yes, please explain:	□ No □ Yes
4. Has the person ever had Guillian-Barre Syndrome (GBS)?	□ No □ Yes
5. Does the person have a long-term health problem with heart, lung or kidney disease, metabolic disease (e.g. diabetes) or other blood disorders (e.g. sickle cell)?	□ No □ Yes
6. Does the person have cancer, leukemia, AIDS or any other immune system concerns?	□ No □ Yes
7. Has the person ever had a seizure, brain, or other nervous system problem?	□ No □ Yes
8. Does the person 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. Does the person smoke or vape?	□ No □ Yes
11. During the past year, has the person received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?	□ No □ Yes
12. Has the person received any vaccinations in the past 4 weeks?	□ No □ Yes

Consent Statement

By 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 Immunization Coalition (IIC) 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 contemplated herein.

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 VaxCare, the VaxCare partner (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 VaxCare 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, IIC 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 317-628-7116 or email: clinic@vaccinateindiana.org

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, Zoster, and/or Covid-19.

Signature: X _____ **Date:** _____

Parent/Guardian signature required if under 18 years old