Indiana Department of Health Consent
2 N Meridian, Indianapolis, IN 46204

Complete the Following for the Person Who is Being Vaccinated

Patient Name: First _________________ Middle______________ Last ___________________
Birth Date _____/_____/________ Age______ Sex ☐ F ☐ M
CHIRP ID _________________ (office use only)
Ethnicity: ☐ Hispanic /Latino ☐ Not Hispanic/Latino
Race: (Check all that apply) ☐ American Indian/Alaskan Native ☐ Asian ☐ Black
☐Native Hawaiian/Pacific Islander ☐ White ☐ Unknown
Phone Number (_____) ________- ____________ Email address: ________________________
Mailing Address: ________________________City: _____________State:_____ Zip:________
Parent/Guardian Full Name ____

Insurance Status

☐ **NO INSURANCE** ☐ **UNDERINSURED** ☐ **AMERICAN INDIAN/ ALASKAN NATIVE**

☐ **MEDICAID**
Company: ________________________Medicaid #: _______________________☐ Don't know

☐ **PRIVATE or COMMERCIAL INSURANCE (NOT MEDICAID)**
Insurance Company: ____________________ Insurance Policy ID: ___________________
Group #___________________ (If one applies)
Policy Holder Name: ____________ Policy Holder Birth Date: ____ /____ /______
Policy Holder Relationship to Patient: ___________

Consent

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 (if insured) listed above to 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 a VaxCare representative.

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I relieve VacXare, the VaxCare partner, 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 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 th e occupational exposure, VaxCare 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, 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, HIB, Polio, Rotavirus, Pneumococcal, Influenza, MMR, Human Papilloma Virus, Meningitis, Varicella, Flu, COVID-19

Signature: X____ Date:___________________

Parent/Guardian signature required if under 18 years old