Funding Source: ☐ Medicaid ☐ Uninsured ☐ Insured ☐ Nat. American or Alaskan ☐ Hoosier H-Wise Pkg C

VACCINE ADMINISTRATION
RECORD OF PARENT/GUARDIAN OR RECIPIENT SIGNATURE

I have been given a copy and have read, or had explained to me, the information in the "Vaccine Information Statement(s)" or the "Important Information Statement(s) for the disease(s) and vaccine(s) checked below. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and the risks of the vaccine(s) requested and ask that the vaccine(s) checked below be given to me or to the person named below for whom I am authorized to make this request.

Confidential Information:

Last Name:	First Name:	Middle Name:	DOB:	Age:	Gender: ☐ **Male** ☐ **Female**
Physician Name:	Medicaid #:	County of Residence:	Birth State:	Race:	Hispanic Origin: ☐ YES ☐ NO
Address:	City:	State:	Zip:	Home Phone: **( )**	
Guardian 1 Last Name:	Guardian 1 First Name:	Guardian 1 Middle Name:	Mothers Maiden Name:	Work Phone: **( )**	
Guardian 2 Last Name:	Guardian 2 First Name:			Patients Social Security Number:	

I agree to allow information about all vaccinations given to me or to the person for whom I am authorized to consent, to be released to school and/or medical care providers to avoid the administration of unnecessary vaccinations and to ascertain immunization status. ☐ YES ☐ NO

Signature of person to receive vaccine or person authorized to make request

____
Signature

☐ Tdap (Tetanus, Diptheria, Pertussis)________________________________

☐ Mcv4 (Menactra) ____