



We help you call the shots!
www.nyc.gov/health/cir

New York City Department of Health and Mental Hygiene
Thomas Farley, M.D., M.P.H.,
Commissioner



Phone: (347) 396-2400
Fax: (347) 396-2559

For Office Use Only	
Date Form Received: ___/___/___	Entered into CIR: ___/___/___
<input type="checkbox"/> Updated Record	Staff Initials: _____
<input type="checkbox"/> New Record	_____

Child / Individual Enrollment/Update Form

Please complete this form. Attach a clear copy of your child's or individual applicant's Lifetime Health Record or other immunization card.

CHECK APPROPRIATE BOX:

- I want to enroll my child in the Citywide Immunization Registry (CIR). I want to update my child's CIR record.
 I want to enroll myself in the Citywide Immunization Registry (CIR). I want to update my CIR record.

Mail this form to:
NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE - CITYWIDE IMMUNIZATION REGISTRY
 42-09 28th Street, 5th Floor, CN 21
 Long Island City, New York 11101-4132

PLEASE PRINT CLEARLY

Child / Individual Applicant's Information

Last: _____ First: _____ Middle: _____

Sex: Male Female

Date of Birth:

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
month			day			year			

Medicaid Number (if applicable):

<input type="text"/>										
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

NAME OF HOSPITAL WHERE CHILD or INDIVIDUAL APPLICANT WAS BORN

NAME OF HEALTH CARE PROVIDER

PROVIDER'S TELEPHONE NUMBER: --

Mother's Maiden Name (name before marriage):

Last: _____ First: _____

Mother's Date of Birth:

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
month			day			year			

Applicant Information

CHOOSE ONE: Self or,

Relationship to Child: Mother Father Guardian
 Other _____
 (please describe, e.g. grandparent)

LAST NAME

FIRST NAME

STREET ADDRESS

APT #

CITY

STATE

ZIP CODE

PHONE

<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	---	----------------------	----------------------	---	----------------------	----------------------	----------------------	----------------------

Primary Language Spoken:

- English Korean Haitian-Creole
 Spanish Chinese
 Arabic Russian
 Other _____

Yes, please send a copy of the immunization record to me.

This is to certify that I am the parent, guardian, custodian, or other such person in parental relationship to the child listed above, or the individual to whom the record relates. I wish to enroll the child listed above in the Citywide Immunization Registry and I consent to the use of the information by the child's health care providers, by DOHMH, or by other authorized organizations for the protection of public health. I understand that all information submitted to the Citywide Immunization Registry will be kept confidential in accordance with section 11.11(d) of the NYC Health Code and New York State Public Health Law 2168.

Signature of Applicant _____

Date _____