NYC Health
www.nyc.gov/health/cir

Citywide Immunization Registry
We help you call the shots
cir@health.nyc.gov

For Office Use Only
Date Form Received: ___/___/___ Entered into CIR: ___/___/___
__ Updated Record Staff Initials:
__ New Record _____

Child or Individual Enrollment or Update Form

(1) Complete this form. (2) Attach a clear copy of your child's or individual applicant's Lifetime Health Record or other immunization card. (3) Mail this form to the address shown ⇨

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, NY 11101-4132

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.**

PLEASE PRINT CLEARLY—

Child or Individual Enrollee's Information:

LAST NAME _____ FIRST NAME _____ MIDDLE NAME _____

Sex (assigned at birth): ☐ Male ☐ Female

DATE OFBIRTH ☐☐/☐☐/☐☐☐☐
month day year

MEDICAID NUMBER (if applicable): ☐☐☐☐☐☐☐☐

NAME OF HOSPITAL WHERE ENROLLING CHILD or INDIVIDUAL WAS BORN _____

NAME OF HEALTH CARE PROVIDER _____

PROVIDER'S PHONE NUMBER: ☐☐☐-☐☐☐-☐☐☐☐

Information of Enrollee's Mother:

MAIDEN NAME (last name prior to first marriage) _____ FIRST NAME _____

MOTHER'S DATE OF BIRTH: ☐☐/☐☐/☐☐☐☐
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: ☐☐☐-☐☐☐-☐☐☐☐

☐ **YES**, please send a copy of the immunization record to me.
You will receive a reply within seven business days of receipt.

This is to certify that I am the parent, guardian, or other person in custodial relation to the child whose information is 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 of the NYC Health Code and New York State Public Health Law 2168. I understand that submitting false, untrue or misleading information to the Department of Health and Mental Hygiene is a violation of New York City Health Code §3.19. I further understand that each incident of such violation is punishable by civil penalties up to $2,000 pursuant to New York City Health Code §3.11.

Signature of Applicant _____ Date _____

Call 311 if you have any questions or concerns, or to request a print copy of this form.