



**For Office Use Only**

Date Form Received:     /    /     Entered into CIR:     /    /      
 Updated Record      Staff Initials:       
 New Record     

## Childhood Enrollment/Update Form

Please complete this form and attach a clear copy of your child'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

Mail this form to:  
 NEW YORK CITY DEPARTMENT OF  
 HEALTH AND MENTAL HYGIENE -  
 CITYWIDE IMMUNIZATION REGISTRY  
 125 WORTH STREET, CN# 64R  
 NEW YORK, NY 10013

PLEASE PRINT CLEARLY

### Child's Information

Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Sex:  Male  Female

Date of Birth:   /   /     Medicaid Number (if applicable):

NAME OF HOSPITAL WHERE CHILD 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:   /   /

### Applicant Information

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

LAST NAME \_\_\_\_\_

FIRST NAME \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_ APT # \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

PHONE     -     -

### Primary Language Spoken:

English  Korean  Haitian-Creole  
 Spanish  Chinese  Other  
 Arabic  Russian

Yes, please mail 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 consent to the use of the information by the child's health care providers, by DOHMH, or by other 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 11.07 (d) of the NYC Health Code.

Signature of Applicant \_\_\_\_\_

Date \_\_\_\_\_