Citywide Immunization Registry

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: ___/___/___
__ Updated Record
__ New Record
Staff Initials: _____

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: ☐☐/☐☐/☐☐☐☐
month day year

Medicaid Number (if applicable): ☐☐☐☐☐☐☐☐

_____
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:
☐☐/☐☐/☐☐☐☐
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 ☐☐☐-☐☐☐-☐☐☐☐

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** _____