Health Department

IMMUNIZATION REGISTRATION FORM

Client EMR #: _____

-Office Use Only-

Program: ☐ Immunizations ☐ WIC

Location: ☐ MC ☐ VERK ☐ SW ☐ SE ☐ Other: _____

Date: _____

SECTION 1: CLIENT INFORMATION *(Please PRINT clearly)-For person to be vaccinated*

Legal Name:

Last Name *First Name* *Middle Name*

Date of Birth: _____ **Other Names Used Since Birth:** _____

MM/DD/YYYY *(Maiden Name, etc.):*

Gender: ☐ Male ☐ Female

Address: _____

Street Address

City *State* *Zip Code*

Phone Number: _____ **Type:** ☐ Mobile ☐ Home ☐ Work ☐ Other

(Area Code) Phone Number

Email Address: _____ **Contact Preference:** ☐ Phone ☐ Mail ☐ Email

Race: ☐ White ☐ Asian ☐ Native Alaskan/American Indian
☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Multi-Racial (Select all that apply)

Ethnicity: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino **Primary Language:**

PARENT/RESPONSIBLE PARTY (IF APPLICABLE)

Last Name:		**First Name:**		**Relationship:**	☐ Parent ☐ Legal Guardian ☐ Self ☐ Power of Attorney
Responsible Party Address if different from client.		***Street Address:***			
City:		***State:***		***Zip Code:***	

If additional children are being vaccinated, and they live at the SAME address and have the SAME health care insurance as the client listed above, then they may be added below. Any child that has a DIFFERENT address and/or insurance than the client listed above must be listed on a separate form.

Name (Last, First)	Birthdate	Sex	Race	Ethnicity