Health and Community Services
Health Department

IMMUNIZATION REGISTRATION FORM

Client EMR #:

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

Legal Name:

Last Name *First Name* *Middle Name*

Date of Birth: *MM/DD/YYYY* **Other Names Used Since Birth:** *(Maiden Name, etc.):*

Gender: ☐ Male ☐ Female

Address:

Street Address

City *State* *Zip Code*

Phone Number: *(Area Code) Phone Number* **Type:** ☐ Mobile ☐ Home ☐ Work ☐ Other

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:**

Are the vaccines desired today needed for travel outside of the U.S.A? ☐ Yes ☐ No

SECTION 2: INSURANCE

Which of the following best describes your insurance coverage?	☐ Blue Cross Blue Shield ☐ Blue Care Network ☐ Health Alliance Plan (HAP) ☐ McLaren Health Advantage ☐ Priority Health ☐ Total Health Care ☐ Tricare	☐ Medicaid ☐ Medicare	☐ I do not have Insurance ☐ Insurance Not Listed *If insurance not listed, does it cover the cost of vaccines? ☐ Yes ☐ No
Name of primary insurance subscriber:	☐ Self ☐ Parent	**Birthdate of primary insurance subscriber:** *mm/dd/yyyy*	
Insurance Policy/Contract #:		**Insurance Group Number:**	

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