

**Macomb County Health Department
Manual Program Registration Form**

Program: Immunization WIC

Office Location: MC SW SE VERK

Date _____ Computer ID # _____
(STAFF USE ONLY)

1. Legal Name _____
(Last Name) (First Name) (Middle Name)

2. Birthdate _____
(Month) (Day) (Year)

3. Street Address _____

4. City _____ State _____ Zip Code _____

5. Telephone # _____ Alternate Telephone # _____
(area code) (area code)
Type of Phone: Cellular/Home/ Work/ Pager/ Friend/ Parent/ Other Cellular/Home/ Work/ Pager/ Friend/ Parent/ Other
(Circle One) (Circle one)

6. Township of Residence _____ County of Residence _____
(Complete if you live outside of city limits)

7. Race--Circle one: American Indian/Native Alaskan Asian Black/African American
Multiracial Native Hawaiian/Pacific Islander White

8. Sex—Circle one: Male Female 9. Ethnicity—Circle, if applies: Hispanic

10. Primary Language _____ Name of Translator _____

11. Parent/Responsible Party _____

Complete this section if your address is different than the address listed for this client:

12. Street Address _____

13. City _____ State _____ Zip Code _____

Add additional children below that live at the same address and have the same insurance as the child listed above and are coming for immunizations today (Please Print)
(Any child that has a different address or different insurance information, must complete a separate form.)

NAME	BIRTHDATE	SEX	RACE	ETHNICITY