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

**Program: Immunization WIC** **Office Location: MC SW SE VERK MTFRC**

Date _____ Computer ID # _____
**(STAFF USE ONLY)**

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

**2**. Birth Date_____ Maiden Name _____
(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 (Circle One) Cellular/Home/ Work/ Pager/ Friend/ Parent/ Other (Circle one)

EMAIL ADDRESS:_____

Contact Preference: Phone Mail Email None (Please only 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 More than one Race Native Hawaiian/Pacific Islander White
(IF selecting More than one Race---Please circle each one that applies)

**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 _____

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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 |
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