

New Jersey Department of Health
Vaccine Preventable Disease Program
P.O. Box 369, Trenton, NJ 08625-0369
609-826-4860 (Fax 609-826-4866)
www.njiis.nj.gov

NEW JERSEY IMMUNIZATION INFORMATION SYSTEM (NJIIS)
CONSENT TO PARTICIPATE

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -

REGISTRANT INFORMATION	PARENT/GUARDIAN INFORMATION (if NJIIS Registrant is a minor)
Registrant Name <i>(Print)</i>	Name <i>(Print)</i>
Date of Birth	Address
Country of Birth	City, State, Zip Code
Name of Primary Health Care Provider	Relationship to Registrant
<p>I have received information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to help remind me when my/my child's immunizations are due and to keep a central record of my/my child's immunization history.</p> <p>I understand that the medical information in the NJIIS may be shared with authorized health care providers, schools, licensed child care centers, colleges, public health agencies, health insurance companies, and others as permitted by New Jersey Law at N.J.S.A. 26:4-131 et seq. and rules at N.J.A.C. 8:57-3.</p> <p>I understand that I can get a copy of my/my child's record from my primary health care provider, my local health department, or the New Jersey Department of Health (NJDOH). The NJDOH may be contacted at the website or telephone number listed above.</p> <p>There is no cost to participate in this program.</p> <p><input type="checkbox"/> Yes, I would like to participate in this program.</p> <p><input type="checkbox"/> No, I do not want to participate in this program.</p>	
Signature of Registrant (or Parent/Guardian, IF Registrant under 18 Years of Age)	
Date	

Name of NJIIS Enrollment Site Regional Cancer Care Associates LLC	Registry ID Number 13250	Medical Record Number
--	-----------------------------	-----------------------

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -