

**Consent for Minor Vaccination**

**MUST BE FILLED OUT COMPLETELY**

**PATIENT INFORMATION**

Name		Date of Birth
Address		
City	State	Zip Code
Medical History (Chronic Diseases, medical problems, allergies, etc.)		
Medications Child is Currently Taking (Name, dose, frequency)		

**INSURANCE**

Insurance Company	Policy # and ID
Policy Holder Name	Employer
Policy Holder Date of Birth	

**CONSENT**

I hereby request and authorize the minor patient named above to receive any necessary vaccines from the **Randolph County Health Department**, and further receive any and all health care services available from and deemed necessary by the staff of the vaccination site in the event of an adverse reaction following vaccination.

This is a one-time consent valid only for the day of the scheduled vaccination:

Appointment Date

I have the authority to consent on behalf of the minor because I am:

- Parent(s)
- Guardian/legal custodian

I authorize  to accompany the above named minor to receive their immunizations. I accept full responsibility for all charges related to immunizations rendered by reason of this authorization.

Parent/Guardian Signature	Printed Name)
Phone Number	Date