

Authorization Form

Permission to Vaccinate:

I authorize _____ (my child's caregiver or other authorized adult) to take my child to the Porter County Health Department for the administration of vaccines that are deemed necessary for the safety and protection of my child.

Family Information:

Child's Name: _____ Birthdate: ____/____/____

Parent / Guardian's Name: _____
Contact Phone Number: _____

Parent / Guardian's Name: _____
Contact Phone Number: _____

Medical Insurance Information:

Group / Plan Name: _____
Member / Insured ID #: _____ Group #: _____
Insured Name: _____ Insured's Birthdate: ____/____/____

Allergies or Other Medical Limitations:

Parent / Guardian's Signature: _____

Date: _____