Hancock Public Health

7748 CR 140, Findlay, Ohio 45840
Ph. 419-424-7870
Fax 419-424-7872

AUTHORIZATION TO CONSENT TO TREATMENT OF VACCINATIONS OF MINOR

Please print all information

I, _____ (must show copy of I.D.) am the parent/legal guardian of _____a minor child, born _____ and am providing signed consent to administration of due vaccinations for the child. I am authorizing _____ an adult, to sign any and all required forms on my behalf. This individual is the child's _____.

This authorization is effective from _____ to _____.

- **Not to exceed 1 year**

_____
Signature of Parent or Legal Guardian

_____ _____
Hancock Public Health Witness Signature Witness Name (please print)

Family Address _____
Telephone: Father _____ Home _____ Work _____
Mother_____ Home _____ Work _____

Child's Birthday _____
Allergies to drugs or foods
_____
_____
_____

Child's Physician _____ Phone _____
Preferred Hospital _____