

CHRISTIAN COUNTY HEALTH DEPARTMENT

P. O. BOX 647, 1700 CANTON STREET

HOPKINSVILLE, KY 42241-0647

PHONE: (270) 8874160 FAX: (270) 887-4165

I GIVE PERMISSION TO _____, TO OBTAIN ANY NECESSARY MEDICAL SERVICES FOR MY CHILD. THE CHRISTIAN COUNTY HEALTH DEPARTMENT HAS MY PERMISSION TO PERFORM ANY NECESSARY PROCEDURES AND/OR GIVE IMMUNIZATIONS TO MY CHILD.

I HAVE READ THE *EPID* INFORMATION SHEET(S) ABOUT THE VACCINE(S), AND UNDERSTAND THE BENEFITS AND RISKS THAT CAN BE ASSOCIATED WHEN IMMUNIZATIONS ARE ADMINISTERED.

ACKNOWLEDGEMENT OF RECEIPT: I ACKNOWLEDGE RECEIVING A COPY OF THE NOTICE OF PRIVACY PRACTICES.

I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME. THIS AUTHORIZATION IS VALID FOR ONE (1) YEAR.

I CAN BE CONTACTED AT _____
DAYTIME PHONE NUMBER

CHILD'S NAME: _____

DOES CHILD HAVE ANY ALLERGIES? YES OR NO
IF YES, PLEASE SPECIFY. _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN

DATE