Boone County
DEPARTMENT OF
PUBLIC HEALTH

1204 Logan Avenue ♦ Belvidere, Illinois 61008
Main Office: 815-544-2951 ♦ Clinic: 815-544-9730
Fax: 815-544-2050 www.boonehealth.org

The mission of the BCDPH is to protect and promote health in Boone County.

CONSENT TO TREAT MINORS FORM

AUTHORIZATION:

The Boone County Department of Public Health has my permission to provide routine immunization for my child and to release immunization information to my child's school and/or medical provider. This consent includes authorizing the following routine health care treatment and services for my child: Medical evaluation, physical exam including vitals, question to be answered regarding the child's medical history, and dispensing immunizations, allergy shots or intramuscular/intravenous antibiotics. The treatment and services for my child may be performed in my absence. *(More than one child may be listed)*

Child's Name: _____

DOB:_____

Child's Name: _____

DOB: _____

LIMITATIONS:

The following is specific limitations on the kinds of medical services for which this authorization is given (if none, state "none.")

_____

_____

_____

_____

_____

Parental contact information for questions regarding treatment:

Parent's Name: _____

Daytime Phone: _____Evening Phone:_____

Cell Phone: _____

Parent's Name:

Daytime Phone: _____Evening Phone:_____

Cell Phone: _____

I hereby indemnify and hold harmless the Boone County Health Department and all their officers, agents, employees, attorneys, directors, insurers, affiliates, subsidiaries, related corporations, successors, heirs and assigns from any and all liability for acting in reliance on this authorization. The individual appointed as proxy (listed above) is permitted to make decisions or consent to the care in my absence. I also agree to accept financial responsibility for all care and services delivered pursuant to this authorization. This authorization is valid for one year (1) following the date signed below unless withdrawn in writing to The Boone County Health Department or restricted by time frame as noted above. *Only one parent's signature is required.*

Permission for_____ to accompany my child(ren).
Full Name

_____ _____
Signature Date

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____
Signature of Parent or Legal Guardian Date