Housatonic Valley Health District

Unaccompanied Minor Form

Authorization to Consent for Treatment of Minors

Date: _____

SECTION A: PATIENT DEMOGRAPHICS INFORMATION *(please print clearly)*

First Name: _____ Last Name: _____

Date of Birth: _____/ _____/ _____ Age: _____ Gender: Female Male Non-binary

Address: _____ City: _____

State: _____ Zip Code: _____

Phone: _____ Email: _____

SECTION B: PARENT/GUARDIAN DEMOGRAPHICS INFORMATION *(please print clearly)*

First Name: _____ Last Name: _____

Date of Birth: _____/ _____/ _____ Age: _____ Gender: Female Male Non-binary

Address: _____ City: _____

State: _____ Zip Code: _____

Phone: _____ Email: _____

_____ (Please Initial) I certify that I have read and understand the Vaccine Information Sheet (VIS) for the influenza vaccine.

PLEASE SELECT TYPE OF CONSENT

CONSENT TO PERMIT CERTAIN INDIVIDALS TO ACCOMPANY CHILD FOR IMMUNIZATION:

I, _____, hereby authorize the following individual to accompany my child to the Town of New Milford Department of Health Clinic for the provision of immunization services.

First Name: _____ Last Name: _____

Phone Number: _____ Relationship: _____

OR

CONSENT TO TREAT UNACCOMPANIED MINOR AT THE TOWN OF NEW MILFORD DEPARTMENT OF HEALTH CLINIC:

I, _____, request and authorize the Town of New Milford Department of Health Clinic and its personnel to administer the requested immunization(s) to my MINOR CHILD.

Please Note: Teen drivers will be asked to stay in our waiting area 15 minutes POST injection for their safety.

This Authorization to Consent for Treatment of Minor will expire on the following event:

Minor's 18th birthday End of calendar year Other date: _____/_____/_____

Authorization and Consent

- I am the parent/legal guardian for the minor child listed in Section A above who is under the age of 18 years old.
- If the minor child exhibits adverse or allergic effects from the administrative of a vaccine, I authorize the Housatonic Valley Health District Clinic to contact and/or administer emergency medical services.
- I understand that my insurance or existing payment method may be billed for the services rendered to the minor listed above.
- I understand this authorization is valid until the 18th birthday of the patient, expiration date noted above OR upon written revocation.
- I understand this Authorization to Consent for Treatment of Minor ("Authorization") does not release me (parent/guardian) from signing an informed consent if required by law. The Housatonic Valley Health District Health Clinic Center may contact me to obtain verbal consent when additional informed consent is necessary.
- I understand this Authorization and the Vaccine Administration Record Form (Intake Form) may be completed prior to **EACH** unaccompanied visit at the Housatonic Valley Health District Health Clinic.
- I have downloaded and read the Vaccine Information Sheet (VIS). I request that the vaccine(s) be given to my minor child named above for whom I am authorized to make this request.
- I have read and understand the contents of this Authorization, which I voluntarily sign.
- A copy of this form shall remain on file in accordance with stat and/or federal law.

Parent/Guardian Signature

Parent/Guardian Signature: _____ Date: _____

Print Name: _____