

## **Housatonic Valley Health District**

## **Unaccompanied Minor Form**

## **Authorization to Consent for Treatment of Minors**

Date:
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irst Name:	Last Name:
rate of Birth:/ Age:	Gender: Female Male Non-binary
ddress:	City:
ate:	Zip Code:
hone:	Email:
First Name:	Last Name:
ECTION B: PARENT/GUARDIAN DEMOGRAPHICS IN	
Date of Birth:/ Age:	Gender: Female Male Non-binary
Address:	_ City:
Address:	

## PLEASE SELECT TYPE OF CONSENT

CONSENT TO PERMIT CERTA	IN INDIVIDALS TO ACC	OMPANY CHILD FOR IMMUNIZATION:		
		by authorize the following individual to accompany my child to the the provision of immunization services.		
First Name:		Last Name:		
Phone Number:		Relationship:		
		OR		
CONSENT TO TREAT UNACC	OMPANIED MINOR AT	THE TOWN OF NEW MILFORD DEPARTMENT OF HEALTH CLINIC:		
		and authorize the Town of New Milford Department of Health nmunization(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.				
	End of calendar year	will expire on the following event:  Other date:/		
	Authoriza	tion and Consent		
<ul> <li>If the minor child exhibit Housatonic Valley Healt!</li> <li>I understand that my ins listed above.</li> <li>I understand this author upon written revocation</li> <li>I understand this Author (parent/guardian) from the Health Clinic Center may</li> <li>I understand this Author prior to EACH unaccomp</li> <li>I have downloaded and minor child named abov</li> <li>I have read and understand</li> </ul>	ts adverse or allergic efforth District Clinic to contact or existing payments and the surance or existing payments are to consent for Touristion to Consent for Touristion and the Vaccine panied visit at the House read the Vaccine Informate for whom I am authoused the contents of this	ild listed in Section A above who is under the age of 18 years old. Fects from the administrative of a vaccine, I authorize the ct and/or administer emergency medical services. In ent method may be billed for the services rendered to the minor of 18th birthday of the patient, expiration date noted above OR of Treatment of Minor ("Authorization") does not release meansent if required by law. The Housatonic Valley Health District verbal consent when additional informed consent is necessary. Administration Record Form (Intake Form) may be completed atonic Valley Health District Health Clinic. Ination Sheet (VIS). I request that the vaccine(s) be given to my rized to make this request.  Authorization, which I voluntarily sign. dance with stat and/or federal law.		
	Parent/G	uardian Signature		
Parent/Guardian Signature:		Date:		

Print Name: \_\_\_\_\_