

CONSENT FOR CHILD TO OBTAIN HEALTH SERVICES WITHOUT GUARDIAN PRESENT- PREAUTHORIZATION

This consent form is only to be used for minors between the ages of 16-17.

Child Information (Under 18 years)

Child's Last Name: _____

First Name: _____

Date of Birth: _____

Age: _____

Home Address: _____

City: _____

State: _____

Zip Code: _____

Parent/Guardian Information:

Parent/Guardian Name: _____

Parent/Guardian Home Telephone: _____

Parent/Guardian Cell Phone: _____

Parent/Guardian Email: _____

I, (please check one)

GIVE consent

DO NOT give consent

for my child, (Insert child's Name) _____,

to receive the health care services indicated below at Joliet West Vaccine Clinic on (date) _____.

- Administration of the COVID-19 Vaccine
- Monitoring for adverse reaction following the vaccine administration
- Emergency assessment and treatment following vaccine administration

Phone number where I can be reached during the provision of health services: _____

Authorization Signature – Parent/Legal Guardian

Date/Time

Printed Name – Parent/Legal Guardian

Relationship to Patient