THIRD PARTY IMMUNIZATION PERMISSION FORM

PURPOSE - TO ENABLE THE PARENT TO AUTHORIZE THE PROVISION OF IMMUNIZATION FOR CHILD(REN) WHILE UNDER THE SUPERVISION OF THE UNDERSIGNED CAREGIVER.

Name of Child: ______________________ **SSN:** ______________________

Date of Birth: ______________________ **Residential Parent:** ______________________

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Mother: ______________________ **Father:** ______________________

Address: ______________________ **Address:** ______________________

______________________ ______________________

Home Phone: ______________________ **Home Phone:** ______________________

Work Phone: ______________________ **Work Phone:** ______________________

I, the undersigned parent/guardian, acknowledge that I have been informed of the routine immunization schedule for children by the Defiance County, Ohio General Health District Immunization Staff (hereinafter: Staff). At this point in time, I elect to have this child, immunized against all communicable diseases, which he/she could be protected.

I hereby give permission to ______________________ (hereinafter: Caregiver) to have my child immunized. The Caregiver is familiar with this child's medical history. This consent is effective until revoked in writing by either parent.

The undersigned hereby releases and forever discharges the Defiance County, Ohio General Health District, its directors, medical staff, agents, employees, and any other persons connected with the County of Defiance, from all claims, damages, and causes of action that may arise from having this child properly immunized, as described herein. This release will be binding on the undersigned, the above child, the spouse of the undersigned, and on the heirs, legal representatives, and assigns of the undersigned.

By signing below, the undersigned has read all the terms of this instrument and understands that he/she is signing a complete release and bar to any claim resulting from having this child immunized, as described herein.

Parent/Guardian: ______________________ **Date:** ______________________

Caregiver: ______________________ **Date:** ______________________

**** Please Note:* *If either refuses to sign, please fill in the above information, and note the refusal in the above-signature blanks, and have a witness sign and date below these locations.*