Lincoln-Lancaster County
Health Department

AUTHORIZED CONSENT AND APPOINTMENT OF AGENT

I authorize the nurses and/or physicians employed or contracted by of Lincoln-Lancaster County Health Department (LLCHD) to screen for, and administer appropriate immunizations to my minor child, _____ (Minor Child), in my absence, and in accordance with the LLCHD's schedules and policies, which I have authorized in writing.

Further, I hereby appoint _____ (an adult 19 years or over), as my agent and representative for the purpose of authorizing and consenting to hospital and/or medical care of the above-named Minor Child for any reaction to vaccines, illness, or injury while such person is in the care of the LLCHD when I am not immediately available to otherwise give such consent.

Authorized Agent's Phone: _____

Known Allergies of Minor Child:_____

Minor Child's Primary Physician: _____

Physician's Phone: _____

Dated this ____ day of _____, 20____

_____
Parent or Guardian Printed Name

_____
Parent or Guardian Signature

_____
Address / City / State / Zip Code

_____
Phone

This statement can be revoked in writing at any time and expires in any event 60 days after it is signed.