Authorization to Consent for Immunizations

Child's Name:	DOB:	Date:
Address:		

I, _____ the parent or legal guardian of the above named child, hereby authorize the following person(s) to provide consent for immunizations in my absence.

Full Name:	Phone:
Full Name:	Phone:
Full Name:	Phone:

I give permission for the above named child to receive the following immunizations as recommended by the Missouri Department of Health and Centers for Disease Control (CDC).

Please mark all immunizations authorized to be given:

- ☐ Dtap/Tdap/Td
- ☐ Hib
- ☐ Rotavirus
- ☐ MMR
- ☐ HPV
- ☐ Influenza
- ☐ IPV
- ☐ Pneumococcal
- ☐ Hepatitis B
- ☐ Varicella
- ☐ Meningococcal
- ☐ COVID-19

Parent or Legal Guardian Signature:	Date:	Phone:

Verified Parent's ID ☐

Witness Signature:	Date:

Updated 12/06/2021