Immunization Letter of Authorization

(I)_____authorize _____

(Parent or legal guardian) (Accompanying Adult)

To bring my (circle) son/daughter _____

(Child/Minors name)

Date of Birth ___/___/___ into Benton Franklin Health District to Obtain necessary immunizations.

_____

(Parent/Legal Guardians Signature)

_____

(Print Parent/Legal Guardians Name)