



**Public Health**  
Prevent. Promote. Protect.

## JO DAVIESS COUNTY HEALTH DEPARTMENT

9483 US RT. 20 WEST • P. O. BOX 318 • GALENA, ILLINOIS 61036 • (815) 777-0263

### CONSENT FOR CHILD'S VACCINATION:

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_

I have read or had explained to me the Vaccine Information Statement(s) for the immunization(s) my child is to receive and understand the risks and benefits.

**I GIVE CONSENT** to **Jo Daviess County Health Department** and its staff for my child named at the top of this form to be vaccinated. **(If this consent form is not signed, then you child will not be vaccinated)**

**I DO NOT GIVE CONSENT** to **Jo Daviess County Health Department** and its staff for my child named at the top of this form to be vaccinated with this vaccine.

I give permission for \_\_\_\_\_, \_\_\_\_\_, to accompany my child  
Name of Person Accompanying Minor Child Relationship to Child  
to his/her Immunization appointment at Jo Daviess County Health Department.

Signature of Parent/Legal Guardian \_\_\_\_\_ Date: \_\_\_\_\_