CONSENT FOR PROVIDING CARE

I, ___________________________________________, parent/legal guardian of ________________________________________

____________________________________________________________ authorize ________________________________________________

(Child’s Name) (Caretaker’s Name)

to bring my child to the Butler County Health Department for diagnosis, treatment, and/or

immunization administration, as needed.

____________________________________________________________

(Parent/Legal Guardian Signature)

____________________________________________________________

(Date)

2/2018

*This agency is an equal provider of services and an equal employment opportunity employer – Civil Rights Act 1964 (CRA)*