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 District for diagnosis, treatment, and/or

immunization administration, as needed.

__________________________________________________

(Parent/Legal Guardian Signature)

__________________________________________________

(Date)

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

Revised 8/2018