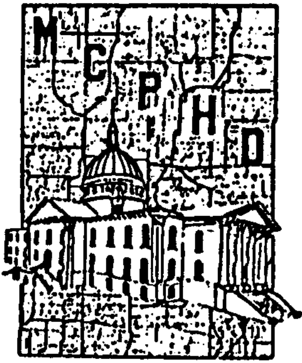


Macoupin County
Public Health Department
805 N. Broad St.
Carlinville, IL 62626
217-854-3223 fax 217-854-3225

I authorize (1) _**Macoupin County Public Health Department**

To release to (2) ____

The following (3) **health and immunization history. Allergies, contraindications to vaccinations or TB skin testing, expected reactions to vaccines, adverse reactions to vaccinations, for TB skin testing a date to return for reading and anticipatory guidance for immunizations or skin test given today**

Regarding(4) ________________________________ Birthdate (5)______/_______/_______

____ _ ________IL__________
Address City State Zip

For the purpose of (7) **providing needed immunizations or tuberculin skin testing.**

I understand that my refusal to authorize to the release of the above mentioned information will prevent the disclosure of the information.

I understand that I have the right to inspect and copy the information that I authorize may be disclosed.

I understand that the information used or disclosed may be subject to re-disclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations.

I understand that the person I am authorizing to use/disclose the information will not receive compensation for doing so.

I understand that I have the right to revoke this authorization at any time by writing to:

Macoupin County Public Health Department
805 North Broad Street Carlinville, IL 62626

If not revoked, this authorization will expire 1 year from the date signed.

(8)_____/______/______ Date signed and Witnessed

(9)___________________________________
Printed name of client

(10)__________________________________
Signature of client

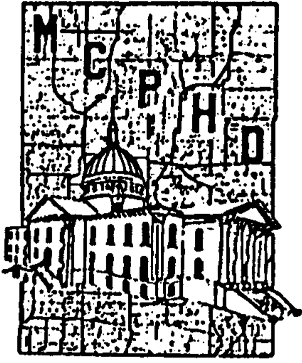
(11) __________________________________
Printed name of Personal Representative

(12)___________________________________
Signature of Personal Representative

(13)___________________________________
Description of Personal Representative

(14)___________________________________
Verification attached

(15)Witness____________________________



Macoupin County
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Macoupin County Public Health Department
Immunization Program

I, ____, give permission to
(Parent of legal guardian)

____ to bring my child/children,
(Person bringing children to clinic)

____
(Child Name) (Birthdate)

____
(Child Name) (Birthdate)

____
(Child Name) (Birthdate)

To the Macoupin County Public Health Department (MCPHD) Immunization Clinic. The above named individual will provide information about my child's health, allergies, immunization contraindications, previous reactions to immunizations, and medications being taken and the Health Department may administer any and all immunizations or tuberculin (TB) skin tests needed or recommended unless they are contraindicated.

____
(Signature of parent of legal guardian) (Date)

____
(Signature of professional performing service) (Date)