



CHAUTAUQUA COUNTY
DEPARTMENT OF HEALTH AND HUMAN SERVICES

PAUL M. WENDEL, JR.
County Executive

CHRISTINE SCHUYLER
*Director of Health and Human Services
(Commissioner of Social Services/Public Health Director)*

**PLEASE COMPLETE AND PRINT THIS FORM AND PRESENT IT AT THE
VACCINATION CLINIC**

**AUTHORIZATION AND CONSENT FOR THE MEDICAL TREATMENT OF A MINOR
Covid-19 Vaccination**

(THIS FORM IS MANDATORY FOR ANY CHILD UNDER THE AGE OF 18)

_____ [Name of Parent/Guardian] as the parent(s) or legal guardian(s) of
_____ [Name of Minor], _____ [Birthdate], I/We permit the
appropriate licensed provider to proceed with the following specifically prescribed administration of
vaccination for my/ our child:

PFIZER, a Covid-19 vaccination approved by FDA Emergency Use Authorization.

Identified Allergies or Special Medical/Other Conditions:

This Authorization will remain valid until my/our child reaches eighteen (18) years of age, or until
revoked or changed.

I/We understand that this Authorization may be revoked at any time, provided that I/We submit a
signed revocation letter. However, any revocation shall not apply to the extent that the Provider has
taken action in reliance hereupon.

Parent/Guardian:

Signature _____ Date _____

Name Printed: _____ Contact Number: _____

Witness:

Signature _____ Date _____

Name Printed: _____