



**Hunt County Health Department, Medical Services  
4815 King Street, Suite B  
Greenville, Texas 75401  
(903) 455-4433  
FAX: (903) 455-4956**

**DELEGATION OF AUTHORITY TO GIVE  
INFORMED CONSENT FOR IMMUNIZATIONS OF A MINOR**

I give permission for

\_\_\_\_\_  
(Name of Adult to Whom Consent is Delegated)

to consent for

\_\_\_\_\_  
(Name of Minor)      DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ to

receive the appropriate immunizations.

Relationship of adult to minor: \_\_\_\_\_

\_\_\_\_\_  
Signature/Parent, Managing Conservator, Legal Guardian,  
or Authorized Person

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of Signature

\_\_\_\_\_  
Signature/Initials of Clinic Staff

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of Immunization

**\*\*CONSENT EXPIRES ONE YEAR FROM SIGNATURE DATE UNLESS WITHDRAWN**

**FAX OR BRING IN ON INITIAL DATE OF SERVICE**