FULTON COUNTY HEALTH DEPARTMENT
COVID-19 CONSENT FORM

Name of CHILD to be immunized: _____ Date of Birth: _____

Please Print the Child's Name

Parent / Guardian Name: _____ Date of Birth: _____

Please Print Your Name

Relationship to child: _____

Your Address: _____

Street Apartment # Town State Zip Code

Phone Number: _____ Email: _____

I am the parent/guardian of the child listed above. I give permission to the Fulton County Health Department to have my child immunized and confirm that this person is familiar with my child's medical history based on the information provided in Armorvax registration. I give them the authority to make decisions about the recommended vaccination to be provided to my child at this visit only. I have instructed them to contact me if they have questions or concerns about the vaccine to be administered. I also grant permission for this record to be released to providers, health departments, schools, day-care centers, WIC, and community and state immunization registry database.

_____ Date _____

Parent/Guardian Signature