Shelby County Health Department

Nursing
20 W Polk St, Suite 202
Shelbyville, IN 46176
Phone (317) 392-6470
Fax (317) 392-6472

Public Health
Prevent. Promote. Protect.

Parent/Legal Guardian's Delegation of Authority

Date: _____

To: Shelby County Health Department

I _____, the parent/legal guardian of
(Parent/Legal Guardian's full name)

_____, delegate to and give my consent to the following
(Child's full name)
authorized person(s) to act on my behalf as my representative for my child during any visits to the Shelby County Health Department for vaccinations, lead, hemoglobin, TB testing and/or other health care services provided by the Health Department.

Delegate's Name (please print)

1. _____
2. _____
3. _____

This Delegation of Authority will remain in effect unless revoked and may be revoked at anytime. Revocations must be made in writing and sent to the Shelby County Health Department.

Signature: _____ Date: _____
(Signature of Parent/Legal Guardian)

Witness: _____ Date: _____

Note: The Delegate and the Witness must be 18 years of age or older. A legal copy of legal Guardians signature must be included (example State ID)