



Wayne County  
**HEALTH DEPARTMENT**  
Where Caring Meets the Community

Wayne County Health Department  
100 South 5<sup>th</sup> Street  
Richmond, IN 47374

**A COPY OF THE PARENT ID AND  
INSURANCE CARD MUST BE WITH  
THESE COMPLETED FORMS.**

## Parent/Legal Guardian's Delegation of Authority

Date: \_\_\_\_\_

To: Wayne County Health Department

I \_\_\_\_\_, \_\_\_\_\_, the parent/legal guardian of  
(Parent/Legal Guardians full name) (Parent Date of Birth)

\_\_\_\_\_, \_\_\_\_\_ delegate to and give my consent to the following  
(Childs full name) (Parent Date of Birth)

authorized person(s) to act on behalf as my representative for my child during any visits to the Wayne County Health Department for vaccinations, lead, hemoglobin, TB testing and/or other healthcare services provided by the Health Department.

In cases of Questions please provide a valid working phone number for the Parent/Legal Guardian: \_\_\_\_\_  
(Parent/Guardian Phone Number)

The Parent/Legal Guardian is required to provide a copy of Driver's License/State Issued Identification Card and Insurance Cards for the child with this form. Delegate must be a person over the age of 18 years old that will be present at the time of service.

### Delegate Information

|                                                         |                                   |                                  |                              |
|---------------------------------------------------------|-----------------------------------|----------------------------------|------------------------------|
| _____<br>(Full Legal Name, must match Photo ID)         | _____<br>(Delegate Date of Birth) | _____<br>(Delegate Phone Number) |                              |
| _____<br>(Delegate Street Address, must match Photo ID) | _____<br>(Delegate City)          | _____<br>(Delegate State)        | _____<br>(Delegate Zip Code) |
| _____<br>(Delegate Relationship to the above child)     | _____<br>(Clinic Date)            | _____<br>(Clinic Location)       |                              |

This Delegation of Authority will remain in effect for the Clinic Date and Location for that one calendar date. New Delegate forms will need to be completed for other Clinic Dates and Locations. Revocations must be made in writing and sent to the Wayne County Health Department.

|                                                               |                          |                                 |                             |
|---------------------------------------------------------------|--------------------------|---------------------------------|-----------------------------|
| _____<br>(Parent/Legal Guardian Signature)                    | _____<br>(Date)          |                                 |                             |
| _____<br>(Witness Signature)                                  | _____<br>(Date)          | _____<br>(Witness Phone Number) |                             |
| _____<br>(Witness Street Address, must match Photo ID)        | _____<br>(Witness City)  | _____<br>(Witness State)        | _____<br>(Witness Zip Code) |
| _____<br>(Witness Legal ID Number or Driver's License Number) | _____<br>(Issuing State) | _____<br>(Expiration Date)      |                             |