



County of Burlington



Health Department: Communicable Disease Physical Location: 15 Pioneer Blvd., Westampton, NJ 08060 Mailing Address: P.O. Box 6000, Mount Holly, NJ 08060-6000
Phone: (609) 265-5533 • Fax: (609) 265-5535
email: bchd@co.burlington.nj.us www.co.burlington.nj.us/health

Public Health
Prevent. Promote. Protect.
Burlington County Health Department
Health Starts Here

Parental Permission for Caregiver to Accompany Minor (Under 18 Years of Age) for Flu Vaccination

Date: _____

To Whom It May Concern,

I, _____ (Parent/Legal Guardian's Full Name), give permission for
_____ (Caregiver's Full Name) to accompany my child,
_____ (Child's Full Name), to receive their flu vaccination at the Burlington
County Health Departments flu clinic.

I understand that my child must meet the clinic's eligibility requirements and that the caregiver will be responsible for ensuring my child follows clinic instructions during the visit. I understand these documents must be presented to clinic staff at the time of my child's vaccination appointment.

As the parent/legal guardian, I will provide my child's caregiver with:

- This document, completed
- A copy of my government-issued photo ID (e.g. driver's license, passport, etc.)
- The completed flu vaccination consent form
- For legal guardians ONLY - proof of legal guardianship

Parent/Guardian Contact Information:

Phone: _____
Email: _____

I agree to receive the flu vaccine and I hereby release Board of County Commissioners of the County of Burlington, Burlington County Health Department and their employees, servants, representatives, officers, and agents (together, the "Indemnities") from any liability for giving me (or the individual on whose behalf I am signing) the flu vaccination. I agree to indemnify, defend, and hold the Indemnitees harmless from any claim made by any person, (including the individual on whose behalf I am signing).

My signature on this form means that all of the information provided in this Application and Consent Form are true to the best of my knowledge. I understand that this form and my signature below are binding on me and my heirs, successors and personal and legal representatives as well as those of the person on whose behalf I am signing. If I am not the person being vaccinated, I warrant that I have the authority to give this consent for the person to be vaccinated.

Signature of Parent/Guardian: _____

Clinic Staff Authorization (For completion by clinic personnel)

Clinic Location: _____
Verified ID of Caregiver: Yes No
Staff Name/Initials: _____
Date of Vaccination: _____