City of Danbury Department of Health and Human Services
Travel Medicine and Immunization Center
155 Deer Hill Avenue • Danbury, CT 06810
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Unaccompanied Minor Form
Authorization to Consent for Treatment of Minors

Date: _____

SECTION A: PATIENT DEMOGRAPHICS INFORMATION *(please print clearly)*

First Name: _____ Last Name: _____

Date of Birth: _____ / _____/ _____ Age: _____ Gender: ☐Female ☐Male

Address: _____ City: _____

State: _____ ZIP Code: _____

Phone: _____ E-mail: _____

SECTION B: PARENT/GUARDIAN DEMOGRAPHICS INFORMATION *(please print clearly)*

First Name: _____ Last Name: _____

Date of Birth: _____ / _____/ _____ Age: _____ Gender: ☐Female ☐Male

Address: _____ City: _____

State: _____ ZIP Code: _____

Phone: _____ E-mail: _____

Relationship: _____ Driver's License #: _____

_____ (Please Initial) I certify that I have read and understand the Vaccine Information Statement (VIS) for each vaccine requested.

SECTION C: The City of Danbury Travel Medicine and Immunization Center will **ONLY** administer the following vaccine(s) to the minor:

INFLUENZA VACCINE:

- ☐ Influenza Vaccine (6 months – 17 years of age)

TRAVEL VACCINE:

- ☐ Typhoid
- ☐ Hepatitis A & B Combination
- ☐ Japanese Encephalitis
- ☐ Rabies
- ☐ Yellow Fever

CHILDHOOD VACCINE:

- ☐ Diptheria, Hepatitis B, Inactivated Polio (DTap-IPV-HepB)
- ☐ Diptheria, Tetanus, Acellular Pertussis, Polio and Haemophilus Influenzae Type B (DTap-IPV-Hib)
- ☐ Diptheria, Polio (DTap-IPV)
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis A & B Combination
- ☐ Haemophilus Influenzae (Hib)
- ☐ Human Papillomavirus (HPV)
- ☐ Meningococcal Conjugate (MCV4)
- ☐ Meningococcal B OMV
- ☐ Meningococcal B Recombinant
- ☐ Measles, Mumps, Rubella (MMR)
- ☐ Measles, Mumps, Rubella, Varicella (MMRV)
- ☐ Pneumococcal Conjugate (PCV13)
- ☐ Pneumococcal Polysaccharide (PPV)
- ☐ Polio

	☐ Rotavirus ☐ Tetanus and Diphtheria (Td) ☐ Varicella

PLEASE SELECT TYPE OF CONSENT

☐ **CONSENT TO PERMIT CERTAIN INDIVIDUALS TO ACCOMPANY CHILD FOR IMMUNIZATION:**

I, _____, hereby authorize the following individual to accompany my child to the City of Danbury Travel Medicine and Immunization Center for the provision of immunization services.

First Name: _____ Last Name: _____

Phone Number: _____ Relationship: _____

OR

☐ **CONSENT TO TREAT UNACCOMPANIED MINOR AT THE CITY OF DANBURY TRAVEL MEDICINE AND IMMUNIZATION CENTER:**

I, _____, request and authorize the City of Danbury Travel Medicine and Immunization Center and its personnel to administer the requested immunization(s) to my MINOR CHILD listed in Section C above.

Please Note: Teen drivers receiving certain vaccinations will be asked to stay in our waiting area 15 minutes POST injection for their safety.

This Authorization to Consent for Treatment of Minor will expire on the following event:

☐ Minor's 18th birthday ☐ End of calendar year ☐ Other date: _____/_____/_____

Authorization and Consent

- I am the parent/legal guardian for the minor child listed in Section A above who is under the age of 18 years old.
- If the minor child exhibits adverse or allergic effects from the administrative of a vaccine, I authorize the City of Danbury Travel Medicine and Immunization Center to contact emergency medical services.
- I understand that my insurance or existing payment method may be billed for the services rendered to the minor listed above.
- I understand this authorization is valid until the 18th birthday of the patient, expiration date noted above OR upon written revocation.
- I understand this Authorization to Consent for Treatment of Minor ("Authorization") does not release me (parent/guardian) from signing an informed consent as required by law. The City of Danbury Travel Medicine and Immunization Center will contact me and obtain my consent when informed consent is necessary.
- I understand this Authorization and the Vaccine Administration Record Form (Intake Form) must be completed prior to the first unaccompanied visit at the City of Danbury Travel Medicine and Immunization Center.
- I have downloaded and read the Vaccine Information Statement (VIS) about each vaccine(s) requested. I request that the vaccine(s) be given to my minor child named above for whom I am authorized to make this request.
- This Authorization applies to the entire series of a vaccine if multiple vaccines are required.
- I have read and understand the contents of this Authorization, which I voluntarily sign.
- A copy of this form shall remain on file in accordance with state and/or federal law.

Parent/Guardian Signature

Parent/Guardian Signature: _____ Date: _____

Print Name: _____