Flathead City-County Health Department

1035 First Ave. West Kalispell, MT 59901
(406) 751-8101 FAX 751-8102
www.flatheadhealth.org

Community Health Services
751-8110 FAX 866-380-1740
Environmental Health Services
751-8130 FAX 751-8131
Family Planning Services
751-8150 FAX 751-8151
Home Health Services
751-6800 FAX 751-6807
WIC Services
751-8170 FAX 751-8171
Animal Shelter
752-1310 FAX 752-1546

This letter provides written consent for ____ (printed name of child) to receive a COVID-19 vaccination on ______________ (date mm/dd/yyyy) at ______________ (time a.m. or p.m.). I have read, or have had explained to me, the Emergency Use Authorization (EUA) for the COVID-19 vaccine. I understand the EUA and ask that the vaccine be given to the person named above for whom I am authorized to make this request for (parent or guardian).

In addition to this letter, I also agree to be available to provide verbal consent for the vaccination of the person named above via telephone call at the date and time the vaccine is given. I will provide verbal consent at the phone number listed below. I understand that if I do not provide both written and verbal consent at the time of vaccination the person named above will not be vaccinated.

Print Parent/Guardian Name: ____

Parent/Guardian Signature: ____ **Date:** ____________________

Parent/Guardian Telephone Number: ____