

Limited Power of Attorney For Immunization and TB Services

Attachment 33e

Name _____ Parent Court Appointed Guardian

Street _____ City _____ State _____

I hereby appoint _____ as my "Agent" to make immunization healthcare
(appointed person)

decisions for the minor or incapacitated person named _____.

- To sign consents for administration and billing of the listed vaccine or TB skin test

Vaccine _____

TB Skin Test

- To receive the Michigan Care Improvement Record provided after receiving vaccines
- To sign any medical service consents in the event that the named minor or incapacitated person has a physiological reaction to the vaccine or TB skin test.

This limited power of attorney shall be valid between _____ and _____ unless I provide an unequivocal written revocation of this specific power of attorney.

By signing below, I attest that I have thoroughly read this Limited Power of Attorney, that I understand its content, and that I am fully authorized to execute it. I certify that information I provide to the Huron County Health Department (HCHD) is true and accurate. To the extent permitted by law, I waive and release HCHD, and its authorized agents, for any and all liability arising, directly or indirectly, out of the vaccine administration, any reaction to the vaccine, or injury sustained while at any clinic run by HCHD staff and its agents. HCHD makes no warranties, express or implied, including but not limited to, implied warranties of merchantability or fitness for a particular purpose regarding the vaccine administered or its effectiveness.

Date: _____

Printed Name of Parent or Legal Guardian

Signature of Parent or Legal Guardian

I, a Notary Public, hereby attest that the person named above appeared before me on the date below and affixed his or her signature to this document as depicted above.

Notary Printed Name _____
Notary Public, _____ County, Michigan
Acting in _____ County
My Commission Expires: _____
Signature _____ Date _____