Norfolk Medical Group at Fountain Point
3901 West Norfolk Avenue, Norfolk, NE 68701

Proxy Immunization Form

Patient Name:_____

Patient Date of Birth:_____

I have been provided a copy of the appropriate Centers for Disease Control and Prevention Vaccine information Materials. I understand the benefits and risks of the vaccines required for my child. I give authorization to Norfolk Medical Group to give the vaccines to my child, in my absence, when accompanied by:

1. _____
2. _____
3. _____

Parent or Legal Guardian

Print Name:_____

Signature:_____

Date:_____

(This form is only good for 180 days or 6 months.)