BRANCH-HILLSDALE-ST. JOSEPH
COMMUNITY HEALTH AGENCY | YOUR LOCAL HEALTH DEPARTMENT
www.bhsj.org

I _____, give my permission for _____,
Name of Parent/Guardian Name of Minor

to receive a Covid-19 vaccine today. Please accept my signature below as permission to receive the vaccine.

_____ _____ _____
Signature of Parent/Guardian Printed name of Parent/Guardian Date

570 N. Marshall Road
Coldwater, MI 49036
(517) 279-9561
(517) 278-2823 Fax

20 Care Drive
Hillsdale, MI 49242
(517) 437-7395
(517) 437-0166 Fax

1110 Hill Street
Three Rivers, MI 49093
(269) 273-2161
(269) 273-2452 Fax

1555 E. Chicago Rd
Suite C
Sturgis, MI 49091
(269) 273-2161