Franklin County Public Health
280 East Broad Street
Columbus, Ohio 43215-4562
(614) 525-3160
www.myfcph.org

Consent For Immunization Of Minors

Immunization Program

The purpose of this consent form is to permit the immunization or emergency treatment when parents or guardians do not personally accompany the minor to the clinic.

I, _____, of _____,
(Name) (Address)

_____, of _____
(Father, Mother, or Guardian) (Minor's Name)

give my consent for _____ to obtain immunizations, and if necessary,
(Authorized Person)

emergency treatment for _____. In the event he/she
(Minor's Name)

has an injury or needs medical care, and all reasonable attempts have been made to contact me at

_____for consent to the treatment have been unsuccessful, I consent to the following:
(Phone Number)

1) Authorization for consent for treatment may be given by _____.
(Authorized Person)
2) The administration of any and all necessary medical treatment by
_____at _____.
(Doctor) (Phone Number)
3) The transfer of the minor, if necessary to_____hospital.

Additional Information

Allergies
Medications being taken
Medical history

Signatures

Parent/Legal Guardian	Date
Authorized Person	Date
Witness	Date

If this consent is signed by a court-appointed guardian, please provide case number and court where guardianship was established.

Court	Case Number

The person authorized should present this form at time of treatment and should be prepared to present identification. For further information or questions call Franklin County Public Health at (614)525-3160.