Consent for Immunization of Minors

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 ____________________________________________,

______________________________________, of ____________________________________________,

(Father, Mother, Guardian) (Minor’s Name)
give my consent for ____________________________________________ to obtain immunizations, and if necessary,

(Authorized Person)

emergency treatment for ____________________________________________. In the event he/she 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 the above named Authorized Person.

2) The transfer of the minor if necessary to the nearest hospital.

Additional Information

Allergies

Medications

Signatures

Parent/Legal Guardian

Date

Authorized Person

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 please contact the Athens City-County Health Department at (740)592-4431.

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