OhioHealth Dublin Family Medicine
7450 Hospital Drive, Suite 4500
Dublin, Ohio 43016

AUTHORIZATION TO TREAT A MINOR

As the parent(s)/legal guardian of ____ DOB: ______________
(Name of Student)

I hereby give my consent to **OhioHealth Dublin Family Medicine** to examine and provide the necessary medical treatment for the above-named patient without my presence.

Patient's Information:

Preferred Language: ____

Insurance ☐ No ☐ Yes

Type of Insurance: ☐ Anthem ☐ Aetna ☐ United Healthcare ☐ Medical Mutual ☐ Other __________________

Managed Medicaid: ☐ CareSource ☐ Buckeye ☐ Molina ☐ Ohio Medicaid ☐ Other ____________________

List any current or prior Medical/Surgical history:

____

____

Allergies to Drugs or Foods:

____

____

List all Medications or Pertinent Information:

____

What services does your child need?

☐ Vaccines
☐ Well-Child Visit
☐ Sports Physicals
☐ Other ____

Parent/Guardian Signature: ____ Date: ___________________

Print Name: ____

Address: ____

Parent 1 Phone Number (home/cell)___________________________ (work)________________________________

Parent 2 Phone Number (home/cell)___________________________ (work)________________________________

Information on this form is considered confidential and law strictly prohibits any disclosure.