

Family Physicians of Gahanna Minor Consent Form

Minor Patient's Name: _____ **DOB:** _____

I hereby acknowledge and give permission to Family Physicians of Gahanna, Inc., to provide medical care for said minor in my absence. A minor can not authorize treatment for themselves.

This medical care may include service and supplies related to the minor's health and may include, but not limited to, taking blood, allergy shots, preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessments or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription.

With this consent form, I give authorization to the person(s) listed below, to bring minor to Family Physicians of Gahanna, for said medical treatment.

Name of Individual (s)/Relationship to Minor

Signature of Parent/Guardian, Caregiver Date

Notary Printed Name

Notary Signature

Sworn to me on (month, day, year) at said time

Commissions Expires

Minor lives with: **Both Parents** **Mother** **Father** **Guardian**

Mother: _____

Address (if different): _____

DOB: _____ Home Phone: _____ Work Phone: _____

Father: _____

Address (if different): _____

DOB: _____ Home Phone: _____ Work Phone: _____

Guardian: _____

DOB: _____ Home Phone: _____ Work Phone: _____