FOREST HILLS PEDIATRICS, LLC
7495 STATE ROAD, SUITE 335
CINCINNATI, OHIO 45255
Phone (513) 232-5512 Fax (513) 232-3341

PERMISSION TO PICK UP PRESCRIPTIONS Note: This form authorizes permission to pick up prescriptions from any persons other than parent/legal guardian whose name is signed below

Name of Child: Date of Birth:

_____ _____
_____ _____
_____ _____
_____ _____

I _____ give the following individual(s) my permission to pick up any prescription or (Parent/Guardian) medication (including a controlled substance) provided to the child. I understand that such authorization does not cover consent to major surgery or any treatment provided outside the offices of Forest Hills Pediatrics, LLC.

Name Relationship to Minor Child

_____ _____
_____ _____
_____ _____

Check one of the following boxes:

____ This notice is effective only on the following date(s): _____
____ This notice is effective from the date below until revoked.

I understand that this notice will not expire unless revoked by me in writing.

Parent/Guardian – Print Name _____

_____ _____
Parent/Guardian - Signature Date

VERBAL CONSENT OBTAINED FROM PARENT/GUARDIAN

Name of Parent/Guardian: _____ Date: _____
Verbal consent effective only on the following date: _____
Name of individual documenting consent: _____
Form sent to parent/guardian to follow-up on verbal consent on (insert date): _____