

# Start Talking!



## Consent Form

for Prescribing Opioids to Minors

Patient Name:
Date of birth:

Prescription name & quantity:
Number of refills:

*The prescribed drug is a controlled substance containing an opioid. This means the medication has been identified by the United States Drug Enforcement Administration as having a potential for abuse, dependence or misuse.*

I certify that I have discussed the following with the minor patient and the patient's parent, guardian or authorized adult:

- (a) The risks of addiction and overdose associated with a controlled substance containing an opioid;
- (b) The increased risk of addiction to controlled substances of individuals suffering from both mental and substance abuse disorders;
- (c) The dangers of taking controlled substances containing opioids with benzodiazepines, alcohol or other central nervous system depressants;
- (d) Any other information in the patient counseling information section of the labeling for the medication required by Federal law.

\_\_\_\_\_  
Signature of prescriber Date

\_\_\_\_\_  
Parent/Guardian Date

\_\_\_\_\_  
Adult Authorized to Consent to Minor's Treatment\* Date

\*An adult to whom a minor's parent or guardian has given written authorization to consent to the minor's medical treatment. The prescription must be limited to not more than a single 72-hour supply if the person consenting to treatment is an adult authorized to consent to a minor's treatment. See, Section 3719.061, Ohio Revised Code.

See the Start Talking! website for tips on talking to kids about drugs  
[StartTalking.ohio.gov](http://StartTalking.ohio.gov)

Patient Name
Date of Birth or
Medical Record Number