Palmetto Palace

This form grants authority to the physician's to administer medication at The Palmetto Palace Mobile Health Unit.

Name of Patient:

_____

Date of Birth (MM/DD/YYYY) :_____

Phone Number: _____

Address City, State & Zip:

_____

The Above listed patient authorizes the following healthcare facility to administer medication.

Facility Name:

_____

Facility Address, City, State & Zip :

_____

Phone Number: _____

I understand that by authorizing the administration of medication from The Palmetto Palace Mobile Health Unit is voluntary.

**I am here by voluntarily consent to give permission** to The Palmetto Palace Mobile Health Unit to allow for my medications to be shipped to their facility, where I will schedule to pick up the medication. If I have questions regarding my medication, I can contact The Palmetto Palace Mobile Health Unit.

_____ _____

Client Signature Date