

TULARE COUNTY HEALTH AND HUMAN SERVICES
HEALTH SERVICES BRANCH
MEDICAL CONSENT AUTHORIZATION FORM

CONSENT TO TREATMENT OF MINOR

Name of minor: _____ Date of birth: ___/___/___

(I)(We), the undersigned, parent (s) / person (s) having legal custody / legal guardianship of above named minor do hereby consent to and authorize the administration of routine physical and dental examinations, including any necessary immunizations, sick call examinations, diagnostic procedures, x-rays, medical and dental treatments deemed necessary by the Tulare County Health and Human Services Agency physicians, dentists and mid-level clinicians while said minor is detained in Tulare County Juvenile detention facilities.

_____/_____/_____
Signature of Parent / Guardian Date signed

_____/_____/_____
Signature of Parent / Guardian Date signed

_____/_____/_____
Witness Title Date signed

Note: If temporary authorization is received over the telephone a second witness is required.

_____/_____/_____
Witness Title Date signed

The probation officer is authorized to arrange for and sign any medical and mental health consent forms necessary for routine and emergency medical, mental health, and dental care for the minor.

_____/_____/_____
Judicial Officer Date signed

Parent / guardian: Please provide information regarding minor's medical history:

Allergies to drugs / foods: _____

Conditions for which minor is currently being treated: _____

Current medications: _____

Primary Care Physician: _____
(Name) (Phone Number)

This form shall be temporary until such time as the signature of a least one parent / guardian can be obtained. Once reasonable efforts have been exhausted the form shall become part of the permanent record.

First Attempt: Date: ___/___/___ Time: ___:___ How was attempt made: _____ Name of Staff: _____
Second Attempt: Date: ___/___/___ Time: ___:___ How was attempt made: _____ Name of Staff: _____
Final Attempt: Date: ___/___/___ Time: ___:___ How was attempt made: _____ Name of Staff: _____