Dane County Juvenile Court Program

City-County Building, Room 200
Madison, WI 53703
Phone: (608) 266-4983 FAX (608)267-4160

MEDICAL CONSENT & RELEASE OF MEDICAL INFORMATION

While placed in Detention/Shelter Home your child ____________________________
D.O.B.______________, may be provided with a health screening and other routine services by a health professional. If any medical concerns or treatment needs appear as a result of that screening or otherwise during their stay, you may be contacted for further permission to provide treatment and/or assistance. We also keep on record the following information and authorizations in the event you cannot be contacted. Please review the questions below and sign in the authorizations section.

Medical Information

Is your child currently taking any medication(s)?_______ YES ________ NO
If YES, name of medication(s):_________________ Dosage ____________Frequency _________
_________________ Dosage ____________Frequency _________
_________________ Dosage ____________Frequency _________

Do you have **any other health concerns** for your child that we should know about? (circle all that apply):
Asthma Diabetes Seizures Allergies (medications, food, other) Heart Condition
Vision/Hearing Problems Tuberculosis Dental Problems Other
Describe any circled above:____

Is there any other health related issues that we should be aware of now? Please describe:___________________
____

Parental Authorization /Consent
(Cross off any of the below that do not apply)

1. **In the event I cannot be contacted, the Dane County Juvenile Court Program is authorized to:**
   a. **Obtain emergency medical care and/or hospitalization or emergency dental care, or to administer medications for the above-named child as may be approved by a physician.**
   b. **Obtain non-emergency care for the above-named child as may be approved by a Health care professional (doctor, nurse).**

2. **I give my permission for:**
   a. **Health Care and/or treatment records and/or information related to my child to be released to the Juvenile Court Program by current or past health/mental health providers as necessary to ensure a continuum of care.**
   b. **Health Care records generated by health care professionals while my child is in Detention/Shelter Home to be released to the designated placement or health care provider following the release of my child from Detention/Shelter Home.**

___________________________________ ___________________________
Parent/Guardian Signature **Date**
(The above authorizations expire 120 days from the date signed)

In case I need to be contacted, I can be reached at (Phone #'s or address):____________________________

My child's regular physician/clinic is:____

Medical Insurance/Assistance? List: Insurance Co. & Policy #'s____________________________________