LA CROSSE COUNTY
HUMAN SERVICES DEPARTMENT

300 North Fourth Street
P.O. Box 4002
La Crosse, WI 54602-4002

CONSENT FOR MEDICAL TREATMENT

LA CROSSE COUNTY JUVENILE FACILITY

I, ____________________________________ as the parent/guardian/custodian of
(name)
________________________________ hereby authorize the La Crosse County Juvenile
(name of juvenile)

Detention Facility and its medical/nursing vendor to provide routine and emergency medical and psychiatric care and treatment for the above-named juvenile. I also agree to pay for any medical, pharmaceutical and hospitalization charges that may be accrued for the above-named juvenile.

____
(Signature)

____
(Date)

Please indicate any exceptions to this consent, including any non-prescription medication your child should not be allowed to take.

____

____

____

Signed and dated form is valid for six months.