San Luis Obispo County
Health Services/Probation Department/Mental Health Services
Consent for Health Care

Authorization for Physical Examinations, Laboratory Tests, Medical and Mental Health Treatment

_____ _____

Name of Child **Date of Birth**

I, _____ hereby consent to thge following for above-named minor/child:

Physical examinations, including medical, dental, vision, podiatric, and vaginal examinations, blood tests, x-rays, immunizations, medical or dental treatment, including surgical and dental operations.

The administration of all necessary treatment and immunizations are under the auspices of a physician if the above-named child is placed in a foster home, boarding home, private or public institution, group home or Juvenile Hall.

Counseling services are provided by SLO County Mental Health therapists. Services may include: mental health screenings and evaluations, individual and group therapy, psychiatric and medication evaluations provided by a psychiatrist, and crisis intervention. In some circumstances, therapists are required to share information about your child with probation staff; and they must report all suspected abuse of children, dependent adults and elders, as well as any plan to seriously hurt themselves or others.

List all known **ALLERGIES** or **REACTIONS** to medications or food: _____

_____

This authorization is valid until revoked. I understand that it will remain in effect until said minor becomes 18 years of age or it is revoked by the parent in writing, whichever comes first. I understand that this authorization will remain in effect for any admissions or re-admissions to the San Luis Obispo County Juvenile Hall during said time period.

_____ _____ _____

Signature of the Parent/Guardian Relationship Date

_____ _____ _____

Home Phone # of Parent/Guardian Cell # Work #

_____

Address of Parent/Guardian

In a case of medical emergency, I may be reached at the telephone numbers below:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Medical Doctor: _____ Phone #: _____

Medical Insurance: _____ Policy/Group # _____
(make a copy of insurance card)

_____

Signature of Witness