

# District VI Juvenile Detention Center

## RELEASE OF RECORDS / CONSENT FOR MEDICAL SURGICAL TREATMENT

I, the undersigned, hereby consents to the performing of physical examinations, by a regularly licensed physician, including immunizations and laboratory tests recommended by the examining physician, upon my:

Son (  )

Daughter (  )

Ward (  )

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(Name of Child)

Upon any entry to District VI Juvenile Detention Center, up to age eighteen (18), from the date hereof, unless such consent is revoked in writing.

I agree and authorize the release of treatment records and historical medical information.

You give permission for \_\_\_\_\_  
to release all treatment records and historical information regarding your child.

I also agree that in an emergency, if medical care or surgery, including the administration of an anesthetic, is needed for said Child, and it appears from competent medical advice that delay in giving such care will be harmful to said child and the undersigned cannot be reached or located in time to sign personal consent, this document will constitute an official consent for such medical care or surgery by a regularly licensed physician, at any time when the above child is in the custody of the District VI Juvenile Detention Center, up to the age eighteen (18), unless such consent is revoked in writing.

I have been informed that the Center is providing mental health / substance abuse evaluations and assessments, regarding the safety and well being of my child.

**In case of emergency:** Home number: \_\_\_\_\_ Work number: \_\_\_\_\_

Other (please specify): \_\_\_\_\_

**Medication:**

Is your child presently taking any medication? Yes (  ) No (  )

It is the policy of the District VI Juvenile Detention Center to provide medications to residents, when prescribed by a licensed physician. Medications must be provided to the Center by the parent or legal guardian, in the original container, with the instructions printed on the container. Please indicate below the child's medication requirements:

Name of Medication	Dosage directions	Pill count

In the event of a discrepancy between the above written instructions and the directions printed on the bottle, the prescribing physician will be contacted, by the Center, to determine the correct dosage. I understand the Center will not be able to dispense medication until the correct dosage is determined.

Signed: \_\_\_\_\_ Relationship to child: \_\_\_\_\_ Date: \_\_\_\_\_

Witness signature: \_\_\_\_\_ Date: \_\_\_\_\_