Medical Consent

Belmont – Harrison Juvenile District
Gender Specific Program

I/We, _____, the parent(s) and/or legal guardian(s) of _____, a minor child, hereby give my/our consent to the administering of all medical care including emergency medical care, laboratory tests, x-rays and anesthesia, psychiatric care or services, as well as the transfer of medical or dental records, and any other medical services ordered by a competent physician(s) who deems them necessary my/our child while she is in the care of Belmont-Harrison Juvenile District Gender Specific Program in the event I/we cannot be immediately located. I/we further understand that if surgery is necessary, and all reasonable efforts to locate me/us have been exhausted, that the Juvenile Judge of your county may give consent. I/we further understand that any medical costs will be borne by me/us and my/our insurance company.

_____
Signature of Parent(s) and/or Legal Guardian(s) Date

_____
Witness Signature Date

Child's Age ____ Child's Birthday _____ Social Security Number _____
Responsible Parent's Insurance: _____
Insurance Co. Address: _____Insurance No:_____
Medicaid Provider: _____
Recipient Billing Number:_____
Does child have any allergies? _____To what:_____
Is child presently taking medication? _____
What are they taking, how much and how often:

	Name	Dosage	When
1.			
2.			
3.			
4.			

Reason for taking medication: _____
_____

Please enclose a copy of the Insurance/Medical Card so that we can keep it on file in case of emergency