

Parent / Guardian Consent for Medical, Dental, Psychological and Treatment

Name of Child, a minor: _____

Name of Parents: _____

Name of Managing Conservator or Guardian, if any: _____

Name of Person giving Consent: _____

Relationship of person giving consent for minor (circle your relationship to the minor) **PARENT LEGAL GUARDIAN ADULT**

TEXAS FAMILY CODE – SECTION 32.001(A)(5) relationship: _____, with the document copy attached:

- 1.I have authority to consent to medical, dental, psychological and surgical services and treatment for this minor.
- 2.I acknowledge and agree with this document and that Van Zandt County Juvenile Probation Department may act through the Director of Juvenile Services, Robert J. Colacino and the designated Health Care Services employees under his direction.
- 3.I consent to medically necessary medical, dental, psychological, and surgical services and treatment for this minor for the period of custody beginning _____, 20____ in the Van Zandt County Juvenile Probation Department, Detention Center or Residential Facility.
- 4.I will provide information about medical and dental benefit plans and insurance for use if services or treatment is needed. In all other cases, this information is confidential, unless I consent to the release of the information for other uses.
- 5.I authorize the medical provider to provide this minor with medically necessary X-ray examination, laboratory testing, anesthetic, medical, surgical, dental procedures or treatment and hospital care. The procedures, treatment, and care must be provided under the general supervision and on the advice of a physician or dentist licensed by the Laws of Texas.
- 6.I authorize the Van Zandt County Juvenile Probation Department to obtain medically necessary X-ray examination, laboratory testing, anesthetic, medical, surgical, dental procedures or treatment and hospital care for this minor, and to administer medication and treatment to this minor as directed and as prescribed by a licensed physician or dentist.
- 7.I consent to medical, psychological, and dental providers releasing to the Van Zandt County Juvenile Probation Department the information regarding the services, treatment, and medication provided to the minor during custody; and Van Zandt County Juvenile Probation Department is authorized to receive the information as needed.
- 8.I understand that I may revoke any or all of the provisions of this document except to the extent that action has been taken in reliance on it, if I give a written and signed documents to Van Zandt County Juvenile Probation Department describing the provision(s) to be revoked.

Signature of Authorized Consenting Person _____
Date

Phone Number (Home) _____
Phone Number (Work) _____
Address

Is the child covered by a medical and/or dental benefit plan, insurance company, Medicaid, etc? ___ If “yes” give ID No. _____

Responsible party(s) carrying coverage: _____ S.S. # _____

Employer: _____ Primary Physician: _____

Insurance Company/ HMO/ PPO: _____

Group/ Policy Number: _____ Address of Claim Office: _____

Medicaid PCA # _____ Primary Physician: _____

Medicaid HMO Blue: _____ Primary Physician: _____

Medicaid Foundation Health # _____ Primary Physician: _____

Signature of Authorizing Consenting Person _____
Date

Phone Number (Home) _____
Phone Number (Work) _____
Address

Witness _____
Relationship / Position _____
Date

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I, _____ print name legibly, position _____, have given an explanation of the consent and authorizations to the person stated in “Person giving consent”. The person verbally gave me the consent and authorizations on this form as he/she as not available in person to execute this form as required by Van Zandt County Juvenile Probation Department. The person has authorized me to enter the above information. I request the person to appear and sign this form.

Signed: _____ **Date/Time:** _____